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GOVERNMENT ESTIMATES IN THE TRICARE MANAGED CARE SUPPORT CONTRACTS

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The Road Not Taken

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I -
I took the one less traveled by,
And that has made all the difference.[1]

Chapter I. Introduction

In 1994, the Department of Defense (DoD) began a journey, to merge the Military Health System (MHS) with the concept of the Managed Care Support Contractor (MCSC).[2] The

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[1] Robert Frost, Complete Poems of Robert Frost, Henry Holt & Company, Inc., 1949.

[2] Department of Defense Directive (DoDD) 5136.1, May 27, 1994, directing the Assistant Secretary of Defense for Health Affairs to exercise authority, direction, and control over the medical personnel, facilities, programs, funding and other health resources within the Department of Defense.

DoD managed health care program, called TRICARE[3], includes the competitive selection of contractors to financially underwrite the delivery of civilian health care services with a uniform, stabilized benefit structure, triple option health benefit features, and a regionally-based health care management system.[4] The goals of TRICARE are to maintain medical readiness[5], improve access to care, provide a secure quality health care benefit, provide a choice of health

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[3] The TRICARE Management Activity (TMA) was established to oversee the Department of Defense managed health care program called TRICARE. See Defense Department Creates "TRICARE Management Activity", TRICARE News Release No. 98-6/P2, dated March 2, 1998, at www.tricare.osd.mil/NewsReleases/News98_06.htm. TMA is a consolidation of the functions of the TRICARE Support Office (formerly known as the Office of CHAMPUS or OCHAMPUS), the Defense Medical Programs Activity, and the integration of health program functions located in the office of the assistant secretary of defense for health affairs (ASD-HA). Id. TMA has its headquarters in the Washington, DC, area at Falls Church, VA, and in the Denver, CO, area at Aurora, CO, the location of the former TRICARE Support Office. Although CHAMPUS refers only to the former indirect or civilian purchased care portion of the Military Health System, TRICARE Policy and Operations Manuals have not been entirely updated and often incorrectly make reference to CHAMPUS instead of TRICARE as the current health care program. Although the CHAMPUS program has ceased to exist for several years, the term itself lingers on as a more commonly recognized (albeit incorrect) reference to the DoD managed health care program.

[4] Briefing by Robert D. Seaman, General Counsel, TRICARE Management Activity, to The Judge Advocate General of the Air Force, January 12, 1999. For a detailed discussion of the triple option health benefit features and regionally-based management system, see *infra* notes 132-140 and accompanying text.

[5] Medical readiness is accomplished by maintaining the health of active duty service personnel and maintaining a preparedness to deliver health care during wartime.

care options, and contain DoD health care costs.[6] The Managed Care Support (MCS) contracts are fixed-price contracts, with risk-sharing features and a bid price adjustment process designed to periodically substitute projected/estimated health care costs with actual health care costs. MCS contracts are 5 1/2 year contracts, with a 6-month phase-in period prior to start-up of delivery of health care services, followed by 5 1-year option periods.

This thesis will explore the bid price adjustment process within the MCS contract, and the Government's methodology used to project/estimate health care costs for use by offerors in the bidding process. Selected as an example for discussion is the Regions 3 and 4 MCS contract. This thesis explores whether the Government, in choosing and engaging a methodology for projecting/estimating health care costs, should have instead chosen another methodology or path; i.e., "the road not taken."

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[6] Briefing by Robert D. Seaman, General Counsel, TRICARE Management Activity, to The Judge Advocate General of the Air Force, January 12,

Chapter II. The Evolution of the Military Health System

A. The first 200 years

TRICARE is the current health benefits program of the Department of Defense, evolving over a period of more than 200 years.[7] Military medical care for the families of active-duty members of the uniformed services dates back to the late 1700s.[8] In 1884, Congress directed that the "medical officers of the Army and contract surgeons shall whenever possible attend the families of the officers and soldiers free of charge."[9]

There was very little change in military medical care until World War II. Most draftees in that war were young men who had wives of child-bearing age.[10] The military medical care system, during this wartime period, could not handle the large number of births, or the care of very young children.[11] In 1943, Congress authorized the

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1999.

[7] The History of CHAMPUS and its Evolving Role in TRICARE, TRICARE Management Activity website at www.tricare.osd.mil/factsheets/history.pdf, 11/25/98, at page 1.

[8] Id.

[9] Id.

[10] Id. Medical resources were devoted during this period to military readiness and combat medical care. See id.

[11] Id.

Emergency Maternal and Infant Care (EMIC) Program.[12] EMIC provided for maternity care and the care of infants up to one year of age for wives and children of service members in the lower four pay grades (E1 - E4).[13]

During the Korean conflict, the existing system of military medical facilities again could not handle the expanded number of patients authorized by statute.[14] On December 7, 1956, the Dependents Medical Care Act was signed into law in order to augment treatment in military treatment facilities (MTFs).[15] The 1966 amendments to this act created the Civilian Health and Medical Program of the Uniformed Services or CHAMPUS.[16] CHAMPUS authorized ambulatory and psychiatric care for active-duty family members, effective Oct. 1, 1966.[17] Retirees, their family members, and certain surviving family members of deceased

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[12] Id.
[13] Id. EMIC was administered by the Children's Bureau, through state health departments. Id.
[14] Id.
[15] Dependents' Medical Care Act of 1956, Public Law 84-569, December 7, 1956, codified at 10 U.S.C. chapter 55.
[16] Military Medical Benefits Amendments of 1966, Public Law 89-614, codified at 10 U.S.C. §§ 1079-1086.
[17] Id.

military sponsors were brought into the program on Jan. 1, 1967.[18]

With the advent of CHAMPUS, the Military Health System (MHS) evolved into two major components. The first was rooted in the military medical treatment facility (MTF) and is sometimes referred to as the direct care system. Usually located on military installations, MTFs provide a source of direct care to local beneficiaries. MTF care is supplemented through the second component consisting of civilian providers, and is sometimes referred to as purchased care or the indirect care system. This supplemental care was administered through the CHAMPUS program.

CHAMPUS was an indemnity program, with the government establishing covered benefits and paying for costs of medical care in the civilian sector subject to maximum allowable charges (CHAMPUS Maximum Allowable Charge or CMAC), with deductibles and cost-shares paid by the

[18] See 10 U.S.C. §§ 1074(a) and (b), 1076, note 1. Retirees who qualify for Medicare under the Social Security Act, 42 U.S.C. § 1395c et seq., are not eligible for CHAMPUS/TRICARE benefits. 10 U.S.C. § 1086(d)

beneficiary.[19] There were no premiums charged, and beneficiaries were free to see any CHAMPUS-certified provider.[20] Cost-shares were 20 to 25 percent of the allowable amount, after meeting the yearly deductible.[21]

Over the past three decades, many new benefits, such as liver, heart, lung and heart-lung transplants, and hospice care, have been added to the program.[22] Procedures that once required admission to a hospital are now done on an outpatient basis. Non-hospital facilities, such as ambulatory surgical centers and free-standing birthing centers, have been added as authorized providers of care.[23]

While the CHAMPUS program increased access and benefits to health care for beneficiaries, the costs associated with the program have also risen significantly. In addition to increased health care access and benefits, increased usage by CHAMPUS-eligible beneficiaries has caused steady increases in CHAMPUS costs. For example, from 1981 to 1990, the CHAMPUS usage overall increased by

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[19] 10 U.S.C. §§ 1079-1086. CHAMPUS Maximum Allowable Charge is now known as TRICARE Maximum Allowable Charge or TMAC.
[20] OCHAMPUS Policy Manual 6010.47-M, Volume II, Chapter 3, Section 11 (May 1994).
[21] Id.
[22] The History of CHAMPUS and its Evolving Role in TRICARE, TRICARE Management Activity website at www.tricare.osd.mil, 11/25/98.

162 percent. [24] During the same period, outpatient visits grew by more than 200 percent.[25] As reflected in budget increases, CHAMPUS costs increased during that period by 350 percent.[26] The DoD health care budget grew nearly 225 percent between 1981 and 1990, reflecting a significant rise in overall health care costs in the Military Health System (MHS), not only in CHAMPUS costs but also in MTF costs.[27]

The CHAMPUS budget for Fiscal Year (FY) 1967 was $106 million.[28] In FY 1996, the TRICARE/CHAMPUS budget was more than $3.5 billion, and more than 20 million claims were received.[29] In FY 1998, TRICARE covered 8.2 million beneficiaries, including 1.6 million active duty members, 2.3 million active duty dependents, and 4.3 million

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[23] Id.
[24] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office (GAO), GAO/HEHS 95-104, March 1995, at 29.
[25] Id.
[26] Id.
[27] Id. Nationally, civilian health care expenditures increased, albeit not as sharply as expenditures in the Military Health System, by 166 percent during the same period. Id.
[28] The History of CHAMPUS and its Evolving Role in TRICARE, TRICARE Management Activity website at www.tricare.osd.mil, 11/25/98.
[29] Id.

retirees and retiree dependents. [30] The annual operating budget was $15.7 billion, employing 144,000 military and civilian personnel in 115 hospitals and 471 clinics.[31]

The systems of health care within the nation continued to change substantially as state governments and the federal government, employers, and consumers tried to address significant increases in medical care costs and issues of access to high-quality medical care.[32] TRICARE, as the DoD's Military Health System (MHS) and one of the nation's largest health care systems, also confronted significant challenges and changes.[33] The MHS performs many difficult and interrelated missions, including providing medical services and support to active-duty members of the armed forces both in peacetime and in war and health care to the families of active-duty personnel, military retirees, their dependents, and survivors.[34]

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[30] Briefing by Robert D. Seaman, General Counsel, TRICARE Management Activity, to The Judge Advocate General of the Air Force, January 12, 1999.
[31] Id.
[32] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26, 1995, at 1.
[33] Id.
[34] Id.

In the post-cold war environment, contingency planning scenarios focus on Operations Other Than War rather than large-scale conflicts.[35] There are continuous efforts to reduce the overall size of the nation's military forces.[36] The changing world environment arguably requires different demands for care with a smaller force, posing continuing challenges to medical readiness.[37] Force reduction efforts, along with federal budget reduction initiatives and base realignments and closures (BRACs) have heightened scrutiny of the size and makeup of DoD's health care system, how it operates, whom it serves, and whether its missions can be satisfactorily carried out in a more cost-effective way.[38] Nevertheless, the military's role, and particularly the mission of the medical departments, has expanded to include peacekeeping and humanitarian missions, such as deployments to Somalia and Haiti, and care to the victims of hurricanes, earthquakes and floods within CONUS and throughout the world.[39]

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[35] Id.
[36] See id. at 1.
[37] Id. at 2.
[38] Id.
[39] Id. at 7.

The MHS offers health benefits to about 8.3 million people and costs over $15 billion annually. The primary mission of the MHS is to maintain the health of 1.7 million active-duty service personnel and to be prepared to deliver health care during times of war.[40] DoD also offers health care services to 6.6 million non-active duty beneficiaries.[41] Health care services are provided primarily through the system of MTFs, which include medical centers, smaller hospitals, and clinics worldwide.[42] Health care services in the MTFs are supplemented through the civilian networks established by the Managed Care Support Contractor.[43]

DoD is experiencing many of the same challenges confronting the nation's health care system, including increasing costs, uneven access to health care services, and disparate benefit and cost-sharing packages for similarly situated categories of beneficiaries.[44] Military

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[40] Id. at 2. Active-duty service personnel includes uniformed members of the Army, Air Force, and Navy/Marine, uniformed members of the Coast Guard, and the Commissioned Corps of the Public Health Service and members of the National Oceanic and Atmospheric Administration (NOAA) who are eligible for military health care. Id.
[41] Id.
[42] Id.
[43] Id.
[44] Id.

hospitals vary significantly in size and medical sophistication and therefore the availability of health care services also varies from facility to facility.[45] Management problems have hampered improvement efforts, including inter-Service rivalries, overlapping responsibilities and inadequate information systems.[46]

The Assistant Secretary of Defense for Health Affairs is responsible for planning, policy development, and oversight of the MHS.[47] These responsibilities include developing guidance on DOD health plans and programs, ensuring that medical programs and systems meet operational readiness requirements, establishing requirements and standards for DOD medical and acquisition programs, and programming and budgeting all MHS resources and funds (except for personnel and construction funds).[48] DoD medical program funds are provided through the Defense Health Program (DHP) appropriations account.[49] The DHP appropriations account provides funds for operation and maintenance, procurement, research and development, and

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[45] Id. at 4.
[46] Id.
[47] Id. at 8.
[48] Id.

non-MTF care.[50] Funding for active duty and reserve medical personnel is appropriated through the military services channels.[51] The Assistant Secretary of Defense for Health Affairs directs the distribution of the funds to the military services, which in turn allocate the funds to their facilities.[52]

Each military service has its own medical department headed by a surgeon general.[53] Each of the service medical departments prepares a medical program budget for the Assistant Secretary of Defense for Health Affairs, develops service-specific programs within the guidance and parameters established by Health Affairs, and operates the MTFs.[54] Each military service also recruits and funds its own medical personnel to administer the medical programs and provide medical services to beneficiaries.[55]

Provision of medical care to military service members during wartime involves a complicated structure of medical

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[49] Id.
[50] Id. at note 5. Funding for military construction is provided through a separate account. Id.
[51] Id.
[52] Id.
[53] Id.
[54] Id.
[55] Id. DoD medical personnel include physicians, dentists, nurses, administrators, medical technicians, veterinarians, and corpsmen. Id.

forces, differing modes of transportation and operations, and complex evacuation policies.[56] During military conflicts, the military services must appropriately respond to the medical requirements of the combat theater Commanders-in-Chief.[57] The military services must have available a medical system that can mobilize and deploy in any theater.[58] In combat, the primary goal of the medical departments is to enable personnel to return to duty as soon as possible and to safeguard those who cannot be returned to duty.[59] The theater of combat operations has four levels, or echelons, of medical support, which become progressively more sophisticated with distance from the battlefield.[60]

The wartime medical support structures vary among the military services depending on the specific missions of

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[56] Id. at 9.
[57] Id.
[58] Id.
[59] Id. at 10.
[60] Id. The four echelons of wartime medical support become progressively more sophisticated with increased distance away from forward areas of combat. Echelon one consists of basic first aid and emergency care in the forward areas. Echelon two involves care at an Aid Station where casualties are triaged, i.e., examined and evaluated to determine priority for continued movement to rear areas. Echelon three involves treating casualties in a medical installation staffed and equipped for resuscitation, surgery, and post-operative treatment. Echelon four involves treating casualties in hospitals staffed and equipped for definitive care.

their combat forces.[61] Each military service structures and sizes its medical organization to support its own forces.[62] The Army Medical Department must provide mobile, flexible medical support across long distances in a variety of wartime environments.[63] The Army's primary mission is preparing for sustained ground combat with a rapidly moving enemy.[64] The Army may operate in a sophisticated battlefield with an infrastructure of communications and facilities, or alternatively in a relatively unsophisticated battlefield in which it may have to create an infrastructure or choose to operate without one.[65]

The Navy medical forces provide global wartime support to both the Navy and Marine Corps, which have different missions.[66] While the Navy generally conducts combat operations at sea, the Marines conduct both amphibious and land operations.[67] The Navy's daily operational missions require a large percentage of the active duty force,

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[61] Id. at 10.
[62] Id.
[63] Id.
[64] Id.
[65] Id.
[66] Id.
[67] Id.

including medical personnel, to be deployed throughout the year.[68]

Air Force medical resources provide medical support to military bases in wartime theaters.[69] The Air Force performs offensive and defensive air operations, both independently and in support of the other military services, as well as non-U.S. forces.[70] Air Force medical forces also provide air transportable hospitals for operational bases and perform most of the air evacuation during wartime.[71]

The rivalries among the Services and their diverse organizational structures and responsibilities hindered efforts to coordinate improvements in the MHS.[72] There were complicated and often conflicting lines of authority and accountability among hospital commanders, the Services, the Service Surgeons General, and the Assistant Secretary of Defense for Health Affairs.[73] Funding within the MHS is not centrally controlled, but instead is controlled by two separate entities. The Assistant Secretary of Defense for

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[68] Id.
[69] Id. at 10-11.
[70] Id. at 10.
[71] Id. at 11.

Health Affairs controls funding for operations, while the Services control funding for the personnel who operate the system.[74]

While the TRICARE Managed Support Contracts are procured centrally by the TRICARE Management Activity within the Assistant Secretary of Defense for Health Affairs, the Lead Agents perform regional oversight.[75] Lead Agents have broad responsibilities for planning, coordinating, and monitoring the care delivered throughout the region by military medical facilities from all the Services in the region, as well as the contract providers.[76] Lead Agents develop integrated health care delivery plans in collaboration with the commanders and staff of the other medical facilities in the region.[77] The Lead Agents do not command or control the facilities, but rather oversee the operations through development and implementation of the

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[72] Id. at 16.
[73] Id. at 16.
[74] Id. at 16.
[75] Id. at 23. For further discussion of the Lead Agents and the regional boundaries of each Lead Agent region, including a current regional map, see *infra* notes 139-140 and accompanying text.
[76] Id.
[77] Id.

regional health plan.[78] Each Lead Agent develops a written utilization management plan, updated annually, for care provided throughout the region, whether in the direct care system or through the Managed Care Support contract.[79] The Lead Agent's plan must be consistent with the DoD utilization management policy issued in November 1994.[80] The Managed Care Support Contractor (MCSC) is required to develop and implement utilization management programs consistent with the DoD policy for care provided outside of the military facilities.[81]

In developing utilization management plans, Lead Agents review the capabilities and capacity for each MTF in their region to perform the required utilization management

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[78] Id. The Lead Agent does not control the funds that flow from the Services to their respective facilities or the flow of TRICARE funds. Id. at 24.

[79] Id. at 26.

[80] Id. See Health Affairs Policy Letter 94-005, Utilization Management (UM) Activities in the Direct Care System Under TRICARE, Stephen C. Joseph, M.D., M.P.H., November 23, 1994, clarified by Health Affairs Policy Letter 96-025, Updated TRICARE Policy Guidelines, Stephen C. Joseph, M.D., M.P.H., January 29, 1996, and Health Affairs Policy Letter 97-046, Clarification of Mental Health Utilization Review Policies, Edwin D. Martin, M.D., Acting Assistant Secretary of Defense, April 22, 1997, and superceded by Health Affairs Policy Letter 98-031, Revised Utilization Management Policy for the Direct Care System, Gary A. Christopherson, Acting Assistant Secretary of Defense, April 15, 1998.

[81] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26, 1995, at 26.

functions for the direct care system.[82] Lead Agents may choose to contract for utilization management services for the direct care system, or the MTF may retain those functions.[83] Regardless of who performs these functions, the activities will be carried out following uniform DoD utilization management policy guidance.[84]

While inter-Service rivalries and competing and overlapping responsibilities within the Military Health System may be unique to the military, many of the challenges facing DoD parallel the challenges facing healthcare nationwide.[85] During the early 1980s and early 1990s, there were significant increases throughout the nation in health care costs and utilization.[86] Throughout this period, MHS costs significantly escalated, and the DoD healthcare budget grew by almost 225 percent.[87] The greatest portion of growth occurred in the CHAMPUS (purchased care) program, which grew by about 350 percent during the period.[88] Meanwhile, national health

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[82] Id.
[83] Id.
[84] Id.
[85] Id. at 14.
[86] Id. at 14-15.
[87] Id. at 15.
[88] Id.

expenditures increased by about 166 percent from 1980 to 1990.[89] DoD could not accurately predict its rapidly increasing spending requirements, resulting in major funding shortfalls well over $3 billion in the late 1980s and early 1990s.[90] Increased health care prices nationwide, a growing military beneficiary population (which historically makes greater use of health care services than its civilian counterparts), and a system of resource allocation for military hospitals that encouraged managers to increase hospital workload all contributed to the cost growth.[91]

One report published in 1989 cites that a major cause of cost growth in the MHS during the 1980s was increases in the price of purchased care services.[92] For example, the average CHAMPUS cost per inpatient admission rose from $2,388 in fiscal year 1981 to $5,395 in fiscal year 1990.[93] The average cost of a CHAMPUS outpatient visit also doubled during this period.[94] According to the report, these price

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[89] Id.
[90] Id.
[91] Id.
[92] Lewin/ICF, The Appraisal of Managed Care Practices in CHAMPUS, Vienna, VA, 1989.
[93] Id.
[94] Id.

increases were due to high medical inflation, new technologies, and cost shifting to the CHAMPUS program by doctors and hospitals facing reimbursement limits from other payers.[95]

Much of the cost growth was due to an increasing population of military retirees and retiree dependents, which meant a larger number of eligible beneficiaries and an increased percentage of eligible beneficiaries who actually used the MHS.[96] The number of CHAMPUS users grew by 162 percent from 1981 to 1990.[97] The increase in CHAMPUS users caused an increase primarily in CHAMPUS outpatient visits, which grew over 200 percent in this period.[98]

Utilization rates for DoD health care services are high in comparison to civilian health care utilization. DoD beneficiaries use health care services as much as 50 percent more than civilians in fee-for-service health care plans.[99] In addition, DoD's resource allocation methods provided incentives for military health care providers to

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[95] Id.
[96] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26, 1995, at 15.
[97] Id.
[98] Id.
[99] Id.

deliver more care.[100] DoD traditionally allocated resources to hospital commanders on the basis of historical workload, including admissions, bed-days, and outpatient visits.[101] Utilization rates of the current year dictated to a great extent the resource allocation for the following year. Thus, military hospital commanders were virtually encouraged to increase utilization rates, in order to receive higher allocations in subsequent years. Hospital commanders had no incentive to control CHAMPUS usage because this budget was not under their control, nor were they held accountable for its use.[102]

Efforts to improve management of the MHS have been hampered by inadequate information systems. Lack of adequate, timely, local information on health care provided to beneficiaries has impeded improvements to the cost-effectiveness of the MHS.[103] Effective health care management requires accurate information about individual physician practice patterns and charges, beneficiary enrollment, patient outcomes, budgeting and resource

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[100] Id.
[101] Id.
[102] Id. Complicated or costly procedures referred to civilian care did not affect military hospital costs. Id.

allocation, and patient and physician scheduling.[104] DoD studies have cited many problems with MHS information systems.[105] The studies found that military information systems could not be relied upon to produce geographically specific analyses.[106]

In an attempt to contain the cost of health care, TRICARE uses a capitation method to allocate health care funds, similar to other managed care programs.[107] Capitation allocates resources based on a fixed amount per beneficiary in the population.[108] As stated above, DoD had in the past been funded on the basis of historical workload, and high resource utilization was rewarded with increased budgets. However, TRICARE adopted a modified capitation method, with the Assistant Secretary of Defense

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[103] Id. at 17.
[104] Id.
[105] Id. at 18. See, e.g., Institute for Defense Analysis, Cost Analysis of the Military Medical Care System, Alexandria, VA, Sept. 1994; RAND Corporation, The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health Care System, Santa Monica, CA, Jan. 1994.
[106] See Institute for Defense Analysis, Cost Analysis of the Military Medical Care System, Alexandria, VA, Sept. 1994; RAND Corporation, The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health Care System, Santa Monica, CA, Jan. 1994.
[107] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26, 1995, at 24.
[108] Id.

for Health Affairs allocating some resources to the Services' medical departments on a per capita basis.[109] DoD's model is a modified capitation approach because funds for some functions are not provided on a per capita basis.[110] Funding for medical support functions not related to the size of the military force, such as the air evacuation system and overseas medical activities, are not capitated.[111] Medical functions unique to the military and related to military readiness and the size of the military force are capitated on the basis of the active-duty population.[112] Funding for operating and maintaining the direct care and purchased-care systems are capitated, using a fixed-dollar amount for each beneficiary using the MHS.[113] The Services' medical departments pass the direct care funds on to the individual medical facilities using their own Service-unique capitation methodologies, making each medical facility commander responsible for providing health services to a defined population for a fixed-dollar amount

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[109] Id.
[110] Id.
[111] Id.
[112] Id.
[113] Id. DoD did not have actual numbers of DoD beneficiaries using the system, but rather estimated the numbers. Id.

per beneficiary.[114] The capitation approach is intended to remove incentives to prolong hospital stays, inappropriately increase the number of services provided, or otherwise provide more costly care than is medically appropriate.[115] TRICARE purchased-care funds are not provided to the medical facilities but are pooled together at the Service level to fund the TRICARE managed care support contracts in each region.[116]

TRICARE also implements a comprehensive utilization management program for the MHS, again similar to private-sector managed care programs.[117] Utilization management programs are designed to ensure appropriate use of medical resources, to support quality care, and to ensure that beneficiaries receive appropriate and coordinated health care services.[118] The primary components of utilization management include pre-certification, concurrent and retrospective review, case management, and discharge planning.[119] Through utilization management, health care administrators evaluate the use of medical resources on an

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[114] Id.
[115] Id.
[116] Id.
[117] Id. at 25.

ongoing basis in an effort to contain costs and ensure health care quality and access.[120]

Private-sector managed care programs use a capitated method to allocate resources and require that beneficiaries enroll and pay premiums in a specific health care plan.[121] These features work together, with enrollment and associated premiums providing a definition of the population that will use the plan and capitation providing a mechanism to budget health care funds on the basis of the number enrolled rather than the type of medical care to be provided.[122] These features create strong incentives for beneficiaries to exclusively use plans in which they are enrolled and have already paid premiums and for health care providers to more efficiently serve beneficiaries.[123] However, the capitation method adopted by DoD arguably could perpetuate existing inefficiencies in the system because the per capita rates are based on past levels of military spending.[124] The Congressional Budget Office (CBO)

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[118] Id.
[119] Id.
[120] Id.
[121] Id. at 27.
[122] Id.
[123] Id.
[124] Id.

reported that projecting future resource requirements on the basis of historical spending patterns could lock past inefficiencies into the system, especially given higher-than-average use of medical care by military beneficiaries.[125] In addition, the initial capitated amounts were not based on the actual number that used the system but on an estimate determined from surveys of military beneficiaries.[126]

Under TRICARE, beneficiaries may choose, subject to some restrictions, between DoD sources of care and private insurers or other programs or health care providers to which they are dually eligible such as Medicare, the Federal Employees Health Benefits Program, and the Veterans Affairs.[127] Even beneficiaries enrolled in the PRIME option may use other health care providers, although at a considerably higher cost share.[128]

The 1980s represented an era not only of rapidly escalating DoD health costs, but also of military downsizing, with military installations being closed or

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[125] Id.
[126] Id.
[127] Id.
[128] Id.

reduced in size, resulting in lower budgets and reductions in the number of MTFs to provide health care. Efforts were made to find ways to improve access to top-quality medical care while keeping costs under control. These efforts led to several CHAMPUS demonstration projects in various parts of the U.S. Foremost among these demonstration projects was the CHAMPUS Reform Initiative or CRI, conducted in California and Hawaii.[129] Beginning in 1988, CRI offered service families a choice of ways in which they might use their military health care benefits.[130] Five years of successful operation and high levels of patient satisfaction convinced DoD officials that they should extend and improve the concepts of CRI as a uniform program nationwide.[131] The new program, known as TRICARE, has been implemented throughout the world.

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[129] The History of CHAMPUS and its Evolving Role in TRICARE, TRICARE Management Activity website at www.tricare.osd.mil, 11/25/98.
[130] Id.
[131] Id.

B. Implementation of TRICARE

On 30 November 1993, Congress directed DoD to implement a health care program that offered beneficiaries a choice of three benefit options.[132] Congress officially named the program TRICARE on 10 February 1996.[133] Implementation regulations for the TRICARE program are found in The TRICARE Final Rule and the TRICARE Policy Manual.[134]

The three benefit options offered under TRICARE are as follows:

1. TRICARE Prime is a Health Maintenance Organization (HMO) or managed care source of care that has low costs. This option is the most actively managed, and is designed to provide comprehensive care to beneficiaries through a network of military and contracted civilian providers. Enrolled members are assigned a military or civilian Primary Care Manager (PCM), from whom

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[132] National Defense Authorization Act for Fiscal Year 1994, Section 731, Pub. L. No. 103-160 (30 Nov 93), codified at 10 U.S.C. § 1097.
[133] National Defense Authorization Act for Fiscal Year 1996, Section 711, Pub. L. No. 104-106 (10 Feb 96) codified at 10 U.S.C. § 1097.
[134] 32 C.F.R. part 199; OCHAMPUS Policy Manual (now known as the TRICARE Policy Manual) 6010.47-M, (May 1994).

they must go through for initial health care.[135] Active duty members and their families do not pay an enrollment fee; retirees and their dependents and survivors pay an annual enrollment fee. Copayments, if any, are lower than under the other options.

2. TRICARE Standard is a fee-for service benefit replacing CHAMPUS, with the same benefits and cost-sharing structure. TRICARE Standard provides beneficiaries with the greatest freedom in selecting civilian physicians but requires the highest beneficiary cost share.

3. TRICARE Extra is a preferred provider option, with a network of providers that offers reduced cost-sharing, and can be used on a case-by-case basis. Beneficiaries do not enroll, or pay annual premiums, but by using physicians in the TRICARE network, are charged copayments that are 5 percent less than under TRICARE Standard.

[135] Beneficiaries need not contact a Primary Care Manager (PCM) for emergency medical care, but are required to notify the PCM within 24 hours of receiving emergency care or as soon as practicable.

The Office of the Assistant Secretary of Defense for Health Affairs sets TRICARE policy and has overall responsibility for the program.[136] Within the Office of the Assistant Secretary of Defense for Health Affairs is the TRICARE Management Activity, which has primary responsibility for program and performance oversight.[137] Army, Navy, and Air Force Surgeons General have authority over the MTFs in their respective services.[138]

As part of the implementation of TRICARE, the Office of Secretary of Defense for Health Affairs initially established twelve regions covering the entire United States. Each region was developed around a major military medical center. As a result of the consolidation of two of the regions, there are now 11 TRICARE Regions covering the United States.

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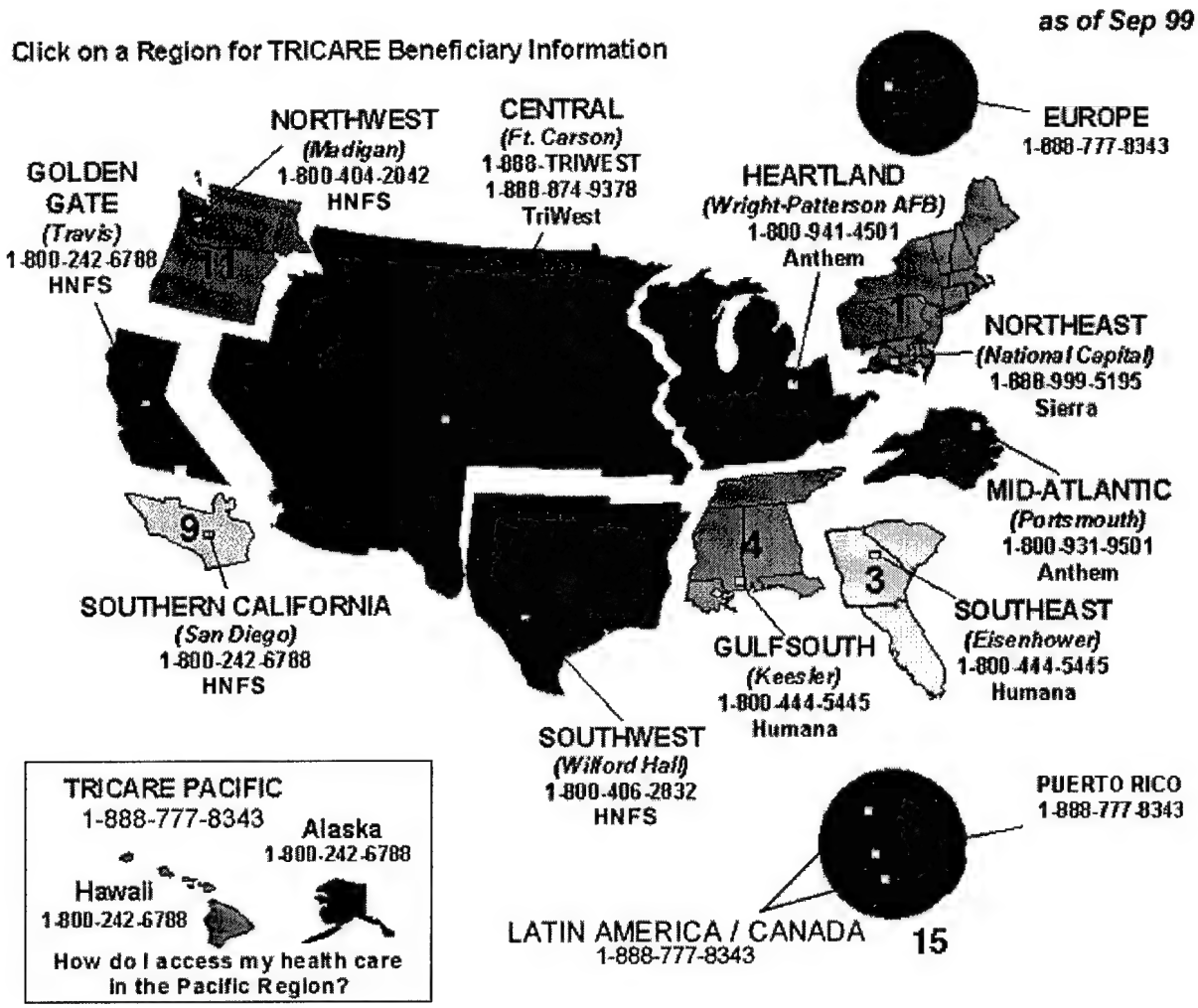
[136] Defense Health Care, *Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE*, Government Accounting Office (GAO), GAO/T-HEHS-98-100, February 26, 1998, at 2.
[137] Id. at 11.
[138] Id. at 2.



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A Lead Agent supported by a joint-Service staff manages each region. The Lead Agent is a general or flag officer and acts both as the Lead Agent for the region and as commander of the local military medical center. The Air Force manages four regions, the Army manages four regions, and the Navy manages three regions. The Lead Agent's staff

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[139] TRICARE regional map as of September 1999 located at www.tricare.osd.mil/tricare/tricaremap2.html. There are 15 total TRICARE Regions, including the 10 TRICARE regions in CONUS, TRICARE

is drawn from each region's military medical facilities and DoD medical program offices.[140]

Hawaii, TRICARE Alaska, TRICARE Europe, TRICARE Latin America/Canada and TRICARE Pacific.

[140] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26,

Chapter III. The Managed Care Support Contracts

Seven contracts covering the 11 regions have been awarded to five Managed Care Support Contractors.[141] Each support contract was awarded to a single private-sector health care company to supplement the care available in the military medical facilities in the region and to provide administrative support to the Lead Agent and MTF commanders and staff.[142] Award of these contracts has not been without controversy. All seven contract awards have been protested. Three of the bid protests were sustained.[143]

1995, at 22. Air Force, Army, Navy/Marine, and Coast Guard staff support the Lead Agent. Id.

[141] Sierra Military Health Services is the Managed Care Support Contractor (MCSC) for the Region 1 contract in the northeast United States. Humana Military Healthcare Services is the MCSC for the Regions 3 and 4 contract in the southeast and gulf south United States. Foundation Health Federal Services is the MCSC for the Region 6 contract in the southwest United States, the Regions 9, 10 and 12 contract in California, Alaska and Hawaii, and the Region 11 contract in the northwest United States. Triwest Healthcare Alliance is the MCSC for the Regions 7 and 8 contract in the central United States. Regions 7 and 8 have been consolidated and renamed as the TRICARE Central Region. Anthem Alliance is the MCSC for the Regions 2 and 5 contract in the mid-Atlantic and heartland United States. However, on April 19, 2001, Anthem, Inc. announced that it had signed a definitive agreement to sell the TRICARE managed care support contract for Regions 2 and 5 to Humana, Inc. The transfer of operations to HMHS is expected to become effective by May 31, 2001.

[142] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26, 1995, at 23.

[143] See Defense Health Care, *Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE*, Government Accounting Office (GAO), GAO/T-HEHS-98-100, February 26, 1998, at 3. See e.g., Physician Corporation of America, 96-1 CPD ¶ 198, 1996 WL

A. Requests for Proposals

TRICARE Management Activity developed a standard RFP for all contracts, describing the program requirements the contractor must meet.[144] The RFPs include a detailed description of the TRICARE program requirements and services to be provided by the contractor, including the following:

- implementing and operating a comprehensive health care delivery system for all TRICARE beneficiaries, including TRICARE Prime and Extra;
- implementing and operating TRICARE service centers that provide enrollment, physician assignment and referral, and appointment functions;
- providing medical personnel and resources to the military facilities if needed to lower overall program costs;
- conducting comprehensive utilization and quality management programs;
- conducting programs to educate providers and beneficiaries on the features of the TRICARE program;

191140; Blue Cross Blue Shield of Texas, Inc., 95-2 CPD ¶ 248, 1995 WL 736603.

- developing procedures to maintain services in the event of the mobilization of military medical personnel from the region; and,
- performing fiscal intermediary services for care provided outside the military facilities, including claims processing and data reporting.[145]

As stated above, the contracts are bid on a competitive basis and considered fixed-price contracts with risk-sharing features. However, only the administrative portion of the contract has a fixed price, while the health care price is subject to adjustments on the basis of risk-sharing provisions in which the contractor and the government share contractor losses and gains beyond a certain level.[146] The risk-sharing and bid price adjustment features are intended to protect both the contractor and

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[144] Defense Health Care, *Issues and Challenges Confronting Military Medicine*, Government Accounting Office, GAO/HEHS 95-104, March 26, 1995, at 24.
[145] Id. The Lead Agents include in the RFP any unique or region-specific requirements that they identify beyond those included in the standard RFP. Id.
[146] Id.

the government from the large risks associated with these complex contracts.[147]

B. The Regions 3 and 4 Managed Care Support Contract

Humana Military Healthcare Services is the Managed Care Support Contractor (MCSC) for the Regions 3 and 4 contract in the southeastern United States.[148] The contract was awarded on 28 November 1995.

Request for Proposals (RFP) No. MDA906-94-R-0002, issued on August 1, 1994, sought proposals to provide health care and associated administrative services in the states of Alabama, Florida, Georgia, Mississippi, South Carolina, and Tennessee, and in portions of Louisiana and Arkansas (Managed Care Support Regions 3 and 4) for TRICARE beneficiaries.[149] The RFP stated that the government intended to award a fixed-price contract (with the price

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[147] Id.

[148] Humana Military Healthcare Services, a subsidiary of Humana Inc., is the primary contractor for the Regions 3 and 4 MCS contract. Blue Cross and Blue Shield of South Carolina, doing business as Palmetto Government Benefits Administrator, provides claims services as a subcontractor under the contract. The Center for Corporate Health provides 24-hour health care advice via telephone as a subcontractor under the contract. CHOICE Behavioral Health Partnership provides mental health services as a subcontractor under the contract.

[149] Request for Proposals (hereinafter RFP) No. MDA906-94-R-0002, § B-1a.

subject to specified adjustments during performance) for a base period with five 1-year options.[150]

The fixed-price nature of the contract was modified by a risk-sharing arrangement under which, in the event of health care cost overruns, the government and the contractor share responsibility for absorbing the excess cost above a set percentage of the contract price.[151] Responsibility continues to be shared under a formula set out in the RFP until the contractor has absorbed overruns equal to its cumulative net gains under the contract and the amount of contractor equity that it put at risk in its proposal.[152] At that point, the contract will begin to function on a cost reimbursement basis, with the government assuming total responsibility and paying for all additional health care costs.[153] The RFP required that offerors place a minimum of $100 million at risk; however, offerors were permitted to exceed that minimum.[154] An offeror's putting

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[150] Id., § B-1d(3).
[151] Id., § G-5f(2).
[152] Id., § G-5f(1).
[153] Id., § G-5f(2)3.
[154] Id.

more equity at risk postpones the point of total government responsibility and is thus favorable to the government.[155]

In accordance with the RFP, actual health care costs were subject to a large number of variables, such as the number of CHAMPUS beneficiaries (and, in particular, the participation of beneficiaries in the Prime (HMO) and Extra (PPO) options), the level of provider discounts, inflation, and the contractor's ability to manage health care utilization.[156] The RFP explained that offerors were to propose "trend factors," (essentially multiplication coefficients) with appropriate justification, for many of these variables.[157] The proposed trend factors represented the offerors' prediction of its cost performance in comparison to the agency's experience during the 12-month period immediately preceding contract performance.[158]

The preceding 12-month period was referred to as the Data Collection Period or DCP.[159] Data projections or estimates regarding the government's experience during the

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[155] Id.
[156] See id.
[157] Id., § L, Exhibit 5.
[158] Id.
[159] Id., § G-5a(3).

DCP period were provided as part of the RFP.[160] Thus, in the event an offeror was predicting that its costs would be identical to those experienced in the DCP, its proposed trend factor would be 1.0.[161] If the offeror was predicting a cost decrease, its proposed trend factor would be less than 1.0, while if it was predicting a cost increase its proposed trend factor would be greater than 1.0.[162]

Because the DCP data provided in the RFP was preliminary, the RFP stated that the data would be revised at two specified points during contract performance.[163] The revised data would lead to adjustments in the contractor's proposed price for purposes of applying the risk sharing formula.[164] Thus, the contractor's actual performance would be more accurately measured in light of its required operating environment.

The RFP distinguished between trend factors over which the contractor was likely to have control and those over which the contractor was unlikely to have control.[165] Controllable trend factors included provider discounts,

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[160] See id.
[161] Id., § L, Exhibit 6.
[162] Id.
[163] Id., § G-5a(4).

resource sharing,[166] and penetration rates.[167] Uncontrollable trend factors included inflation, volume tradeoff, and diagnostic related group capital and direct medical education expenditures.[168]

In projecting actual health care costs, the RFP stated that offerors' proposed controllable trend factors would be evaluated based upon the justification and documentation provided for the trends in the business proposal and upon the government's estimate of the likely trends under the offeror's approach.[169] Based on this assessment, the agency would adjust the offeror's proposed figures to reflect the agency's judgment regarding the actual costs that would be incurred under each offeror's approach.[170]

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[164] Id., § G-5f.
[165] See id., § M-3d(4).
[166] See id., § M-3d(4). Section C-2a of the RFP contains Resource Sharing provisions. Resource Sharing is an agreement between the MCSC and an MTF for the provision of personnel, equipment, supplies, facilities, and in some cases, cash payments, to enhance the capability of the MTF to provide care to DoD beneficiaries. Id., § C-2a. The agreements may be "internal," where MCSC resources are brought into and "shared" in the MTF, or "external," where MTF resources are brought into and "shared" in a civilian facility. Id. The MCS contract is structured so savings to DoD from the use of Resource Sharing agreements are factored in by the MCSC and realized up front by DoD through a reduced bid price. Id.
[167] Id., § M-3d(4).
[168] Id.
[169] Id.
[170] See id.

The RFP advised offerors that the agency would substitute its independent government cost estimate (IGCE) factors for those proposed by offerors in the case of trend factors over which the contractor was unlikely to have control (such as inflation), except in instances in which an offeror had a signed capitation agreement with specified capitation rates.[171] With respect to the trend factors under the contractor's control (such as utilization management, the percentage of beneficiaries participating in the HMO and PPO options, and discounts offered by health care providers), the RFP provided for the agency to evaluate the realism of each proposed factor based on the agency's judgment about the likely trends under the offeror's approach and make appropriate adjustments.[172] The agency's final assessment of projected actual health care costs for each offeror would reflect the costs proposed, as modified by the agency's adjustments of either controllable or uncontrollable factors.[173] The total probable health care cost for a proposal would be the offeror's proposed health care cost, as modified above, plus a fixed

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[171] Id., § L, Exhibit 6.
[172] Id., § M-3d(4).

administrative price and the offeror's health care profit.[174]

The DoD received five proposals (including an alternate proposal) from four offerors, including HMHS and three other firms, by closing time on March 3, 1995. All proposals were included in the competitive range. At the conclusion of discussions, DoD requested submission of best and final offers (BAFO) by August 2, 1995. The contract was awarded to HMHS on November 28, 1995.[175]

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[173] Id.

[174] Id., § M. The RFP stated that, in the selection of an awardee, technical content would be more important than cost. Id. Specifically, the weighting ratio was set out as 60 percent for technical and 40 percent for cost. Id. The technical score was the result of the evaluation of 14 tasks to be performed, plus experience and performance. Id.

Chapter IV. Risk Allocation in Government Contracting

Government contracting involves risks of unanticipated events that occur during contract performance and difficult circumstances caused by matters inherent in the performance of work that are not recognized until the difficulties are encountered or substantial cost increases become apparent.[176] The process of assigning these risks to the parties, either through contractual language or by courts or boards during dispute resolution, is generally referred to as risk allocation.[177]

Risks can be allocated by the selection of the pricing arrangement reflected by the selected contract type.[178] Under firm-fixed-price contracts, the contractor bears the majority of these risks.[179] This contract type places upon the contractor maximum risk and full responsibility for all costs and resulting profit or loss.[180] A firm-fixed-price contract provides maximum incentive for the contractor to

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[175] RFP, *supra* note 149, Transmittal Sheet.
[176] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 239 (3rd ed. 1995).
[177] Id.; see Ralph C. Nash, Jr., *Risk Allocation in Government Contracts*, 34 GEO. WASH. L. REV. 693 (1966).
[178] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 239 (3rd ed. 1995).
[179] Id.
[180] FAR § 16.202-1.

control costs and perform effectively.[181] Contrarily, under cost-reimbursement contracts the Government accepts the risks of increased costs, delays, and nonperformance.[182] This type of contract provides for payment of all allowable incurred costs to the extent prescribed in the contract.[183] Thus, a cost-reimbursement contract places minimum risk on the contractor for costs and performance under the contract.[184]

Risks may be expressly allocated within these types of contracts through contract clauses.[185] Standard clauses provide for time extensions or price adjustments if various conditions differ from those expected or represented.[186] Special clauses covering other events or circumstances may also be included in contracts.[187]

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[181] Id.
[182] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 239 (3rd ed. 1995).
[183] FAR § 16.301-1.
[184] See id.
[185] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 239 (3rd ed. 1995).
[186] Id. Examples of standard clauses expressly providing for time extensions or price adjustments based upon various conditions are Changes, Differing Site Conditions, Suspension of Work, and Default clauses. Id. These clauses are discussed in detail in various chapters of JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS (3rd ed. 1995).
[187] Id.

Common law methods of risk allocation may offer a remedy in the absence of contract clauses or may provide a basis for seeking a remedy through contract clauses such as the Constructive Change/Suspension of Work clause.[188] The fundamental rules of risk allocation arise from these common law principles.[189]

A. Government Estimates

Common law risk allocation principles dictate that the Government is liable if it misleads the contractor by making incorrect statements or failing to disclose information that it possesses.[190] For example, the Government often provides offerors estimates of the amount of work anticipated or other matters that are important in preparing an offer.[191] Although estimates are not statements of fact,[192] by furnishing estimates to offerors,

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[188] Id.
[189] Id.
[190] Id. at 250.
[191] Id.
[192] Regarding the Government's liability for incorrect statements and nondisclosures, the Government is most clearly liable when it makes a misstatement of fact. Id. at 251. Sources of misstatements of fact include specifications, bidding documents, and contract provisions. Id. The Government may be liable for incorrect information given about the availability of certain items or about pricing information provided during negotiations. Id. at 252. Further, the Government may also be liable for misinformation provided to contractors regarding laws and

the Government may be held to have made implied representations concerning factual aspects of the estimates, such as estimating methods or factors considered in arriving at the estimates.[193]

The Government must use due care in gathering relevant data and information and using that data and information in the estimating process.[194] Ordinarily, an estimate is used

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regulations applicable to the contract, as well as misrepresentations regarding taxes applicable to the contract. Id. The responsibilities of the contracting parties regarding knowledge of applicable laws may depend upon the type of solicitation. Id. at 253.

[193] Id. at 253.

[194] Fairfax Opportunities Unlimited, Inc., AGBCA No.1 96-178-1, 98-1 BCA ¶ 29,556 (finding the Government negligent for unreasonably failing to update solicitation work estimates with the most current and reliable data); Ralph Construction, Inc. v. U.S., 4 Cl. Ct. 727, 727-28, 732 (1984)(finding Government exercised reasonable care in preparation of estimated quantities for housing maintenance services contract previously performed in-house, basing estimate on completed service orders and work orders performed by government personnel during the 12-month period preceding the issuance of the solicitation); Womack v. United States, 182 Ct. Cl. 399, 412-13, 389 F.2d 793, 806 (1968); see also Chemical Technology, Inc. v. United States, 227 Ct. Cl. 120, 645 F.2d 934 (1981)(finding estimate negligently prepared because Government did not take into account all relevant factual data); Skip Kirchdorfer, Inc. v. United States, 14 Cl. Ct. 594 (1988)(determining Government estimates were negligently prepared and damages were due the contractor where actual number of daily services calls exceeded the estimates by more than 100 percent); Steelcare, Inc., GSBCA No. 5491, 81-1 BCA ¶ 15,143 (finding Government negligent in estimating by failing to adequately investigate amount of work to be performed); Atlantic Garages, Inc., GSBCA No. 5891, 82-1 BCA ¶ 15,479 (finding Government negligent in estimating by failing to use all available information and in using faulty estimating method); LBM, Inc., ASBCA No. 39606, 91-2 BCA ¶ 24,016 (determining that Government did not consider the rate of increase in historical data in formulating estimate of service calls for heating/air units on a naval installation); Management & Training Corp., GSBCA No. 11182, 93-2 BCA ¶ 25,814 (finding Government liable for not including a chilled-water

only where there is a recognized need for guidance to offerors on a particular point but specific information is not reasonably available.[195] An estimate made under these circumstances must be the product of such relevant underlying information as is available to the author of the invitation.[196] Assuming that the offeror acts reasonably, he is entitled to rely on Government estimates as representing honest and informed conclusions.[197] While the Government is not required to be clairvoyant, it is obligated to base estimates promulgated for bidding-invitation purposes on all relevant information that is reasonably available to it.[198]

The Government uses due care if the estimate is reasonably based upon the available data.[199] The Government

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component in its estimate of costs to be used as basis for utility rate increases during the contract period).

[195] Womack v. United States, 182 Ct. Cl. 399, 412-13, 389 F.2d 793, 806 (1968), *citing* Y.L. Yoh Co. v. United States, 153 Ct. Cl. 104, 105, 288 F.2d 493, 494 (1961).

[196] Womack v. United States, 182 Ct. Cl. 399, 412-13, 389 F.2d 793, 806 (1968).

[197] Id., *citing* Snyder-Lynch Motors, Inc. v. United States, 154 Ct. Cl. 476, 479, 292 F.2d 907, 909-10 (1961).

[198] Womack v. United States, 182 Ct. Cl. 399, 412-13, 389 F.2d 793, 806 (1968).

[199] Ralph Construction, Inc. v. U.S., 4 Cl. Ct. 727, 727-28, 732 (1984)(finding Government exercised reasonable care in preparation of estimated quantities for housing maintenance services contract previously performed in-house, basing estimate on completed service orders and work orders performed by government personnel during the 12-

may go beyond regulatory requirements, but is under no legal obligation to do more.[200]

In addition to implied representations concerning factual aspects of estimates, the Government may be held to have impliedly warranted the reasonable accuracy of the estimates.[201] The theory of warranty of reasonable accuracy must be distinguished from factual representations concerning the preparation of the estimates, since the theory of warranty of reasonable accuracy does not necessarily involve existing facts.[202] Under the theory of warranty of reasonable accuracy, the Government may be

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month period preceding the issuance of the solicitation); Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992); Timber Investors, Inc. v. United States, 218 Ct. Cl 408, 587 F.2d 472 (1978); Anthony G. Bamonte, AGBCA 77-154, 78-2 BCA ¶ 13,508 (finding Government made good faith effort resulting in reasonably accurate estimate); Broken Lance Enter., Inc., ASBCA No. 22588, 78-2 BCA ¶ 13,433 (finding Government estimates prepared with considerable care by knowledgeable persons); Mattatuck Mfg. Co., GSBCA No. 4847, 80-1 BCA ¶ 14,349 (determining that estimates were derived from sophisticated computer system).

[200] Medart, Inc. v. Austin, 967 F.2d 579, 582 (Fed. Cir. 1992)(holding that Government followed reasonable regulatory estimating procedures). The Government may wish to go beyond the requirements of regulations in order to secure the best prices. Id. Offerors may otherwise inflate bid prices to cover uncertainties. Id.

[201] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 253 (3rd ed. 1995).

[202] Id.

found liable for an inaccurate estimate absent a lack of due care or fault.[203]

Regarding indefinite quantity contracts, the Armed Services Board of Contract Appeals has determined that it will not examine the reasonableness of estimates in such contracts.[204] The board determined that requiring the Government to ascertain and then honor estimates of orders negates the very flexibility sought for by the Government and for which the parties contracted.[205] What is reasonable in any given case will depend upon the discernable intent of the parties, as indicated by the contract type, the clauses incorporated into the contract, and as determined by the facts and circumstances of the individual case.

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[203] Id. at 254; see e.g., Cedar Lumber, Inc. v. United States, 5 Cl. Ct. 539 (1984); Everett Plywood & Door Corp. v. United States, 190 Ct. Cl. 80, 419 F.2d 425 (1969).

[204] C.F.S. Air Cargo, Inc., ASBCA No. 40694, 91-2 BCA ¶ 23,985, *aff'd* 972 F.2d 1353 (Fed. Cir. 1992); see also DynCorp, ASBCA No. 38862, 91-2 BCA ¶ 24,044 (refusing to examine the reasonableness of an estimate in Navy indefinite quantity supply contract).

[205] C.F.S. Air Cargo, Inc., ASBCA No. 40694, 91-2 BCA ¶ 23,985, *aff'd* 972 F.2d 1353 (Fed. Cir. 1992). For a discussion of negligent estimate cases involving indefinite delivery contracts, see Major David A. Wallace et al., *Contract and Fiscal Law Developments of 1998 -- The*

B. Government Nondisclosure of Information

The Government's liability for nondisclosure of information is grounded upon an implied duty to disclose information that is vital for the preparation of estimates or for contract performance.[206] The implied duty reflects general contract law concepts of good faith and fair dealing.[207] This duty arises when the balance of knowledge is clearly on the Government's side, and thus the Government has "superior knowledge" to the contractor.[208] The Government information must be vital to the performance of the contract and the nondisclosure must have in some way misled the contractor or did not put the contractor on notice to inquire.[209] The obligation of the Government to

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[206] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 255-56 (3rd ed. 1995); see e.g., Helene Curtis Indus., Inc. v. United States, Ct. Cl. 437, 312 F.2d 774 (1963)(finding a Government duty to disclose vital information that it was aware the offerors needed but did not have).

[207] Id. at 256; see Restatement, Second, Contracts § 205; Dygert, Implied Warranties in Government Contracts, 53 MIL. L. REV. 39 (1971).

[208] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 253 (3rd ed. 1995); see J.A. Jones Constr. Co. v. United States, 182 Ct. Cl. 615, 390 F.2d 886 (1968); J.F. Shea Co. v. United States, 4 Cl. Ct. 46 (1983). The elements of a superior knowledge claim are as follows: (1) The Government had knowledge of facts; (2) The contractor neither knew nor should have known the facts; and, (3) The Government should have been aware of the contractor's ignorance. J.A. Jones Constr. Co. v. United States, 182 Ct. Cl. 615, 390 F.2d 886 (1968).

[209] GAF Corp. v. United States, 932 F.2d 947 (Fed. Cir. 1991).

disclose applies to specific information that impacts the cost of the work.[210] However, a contractor is expected to be familiar with information generally known within the particular industry.[211] Similarly, a contractor is expected to have knowledge of information that is reasonably available from other sources.[212] The size and sophistication of a contractor bears on what information the contractor should be able to obtain on its own.[213] The Government must have reason to know of the contractor's ignorance of vital information, and this may be evident when the contractor expressly requests the information from the Government.[214]

C. Exculpatory or Disclaimer Clauses

As discussed above, risks may be expressly allocated within contracts through contract clauses.[215] Exculpatory

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[210] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 257 (3rd ed. 1995).
[211] Id. at 262.
[212] Id. at 263.
[213] Id. at 264; see Tyroc Constr. Corp., EBCA No. 210-3-83, 84-2 BCA ¶ 17,308 (holding that it is especially important in a solicitation involving a small business set-aside project for the Government to reveal available information bearing on the conditions of performance).
[214] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 264 (3rd ed. 1995).
[215] See *supra* text accompanying note 10.

or disclaimer clauses may be utilized to warn the contractor of potential problems or otherwise seek to impose risk of these problems on the contractor.[216] These clauses are closely scrutinized and may not be fully enforced, depending upon the facts and circumstances of the particular case and the impact upon the contractual relationship.[217] However, if an exculpatory provision is not against public policy and is clearly worded to indicate to the contractor that the Government does not expressly or impliedly warrant the accuracy or usefulness of information or material that it furnishes, it will likely be enforced.[218] Enforcement is most readily imposed when the exculpatory language gives the contractor specific information on the inferior nature of the information.[219] In that situation, the contractor is expected to include contingencies in its price to cover such risks.[220] The terms of the exculpatory language will generally be

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[216] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 348 (3rd ed. 1995).
[217] Id.
[218] Id. at 352.
[219] Id.; Wunderlich Contracting Co. v. United States, 173 Ct. Cl. 180, 351 Fe.2d 956 (1965)(determining that the exculpatory language gave the contractor specific information on inferior condition of drawings).

enforced unless the parties did not contemplate enforcement when the contract was entered into, or if enforcement would be inconsistent with other significant contract provisions.[221] Exculpatory clauses will be enforced unless enforcement would be unreasonable under the circumstances.[222]

D. Duty of Coordination

The duty of coordination requires the contractor to review contract specifications to ensure that there is no misplaced or omitted information.[223] The contractor has a duty to ensure that the specifications contain information necessary for subcontractors to include all work required

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[220] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 352 (3rd ed. 1995); see Commercial Constr. Corp., ASBCA No. 24087, 80-1 BCA ¶ 14,312 at 70,532.

[221] Commercial Constr. Corp., ASBCA No. 24087, 80-1 BCA ¶ 14,312 at 70,532.

[222] Id.; see P.J. Maffei Bldg. Wrecking Corp. v. United States, 3 Cl. Ct. 482, 487 (1983) *aff'd* 732 F.2d 913 (Fed. Cir. 1984)(determining that exculpatory provisions that "some drawings of some of the existing conditions" and "quantity, quality, completeness, accuracy and availability [of contract drawings was not guaranteed]" put contractor on notice that Government did not imply representations regarding the drawings); PRB Uniforms, Inc. v. United States, 706 F.2d 319 (Fed. Cir. 1983)(denying recovery where clauses advised that Government did not expressly or impliedly warrant adequacy of technical data package); John Massman Contracting Co. v. United States, 23 Cl. Ct 24 (1991)(holding that site investigation clause warning of hazards arising from weather conditions precluded recovery for delays caused by such conditions).

in the bids.[224] The risk is therefore upon the contractor to detect where the contract fails to contain all relevant information.[225] Contractors will not find relief where necessary information is omitted from certain drawings but included in other drawings in the solicitation.[226] The contractor's responsibility to coordinate its subcontractors' bids conforms with the principle that the Government's privity of contract lies with the prime contractor, and subcontractors' bids are not considered as separate entities from the prime bid.[227]

The duty of coordination does not extend to circumstances where specifications in the contract are

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[223] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 363 (3rd ed. 1995).

[224] Id.

[225] Id.

[226] Id.; see, e.g., Shumate Constructors, Inc., VABCA No. 2772, 90-3 BCA ¶ 22,946 at 115,195 (denying relief where pipe with asbestos insulation was listed on a demolition drawing but not on an asbestos abatement drawing); Caddell Constr. Co. VABCA No. 3509, 93-3 BCA ¶ 26,114 (denying recovery where smoke dampers were on control drawings but not on ductwork drawings); M.C. Dean Elec. Contracting, Inc., ASBCA No. 38132, 90-1 BCA ¶ 22,314 (denying relief where electrical work was specified on general drawing but not on an electrical drawing); Price/CIRI Constr., ASBCA No. 36999, 89-3 BCA ¶ 22,010 (denying relief where electrical work was specified on an architectural drawing but not on electrical drawings).

[227] See R.A. Burch Constr. Co., ASBCA No. 39017, 90-1 BCA ¶ 22,599 at 113,396 (rejecting prime contractor's argument that subcontractor bid should be treated as separate entity from prime bid, and denying relief where electrical work was omitted from electrical drawings but included on mechanical drawings).

defective.[228] Where the drawings or specifications are defective, the Government is not exculpated from liability, as no amount of coordination would have cured the defect.[229] A contractor has no obligation to find conflicts within drawings and/or specifications unless the defects are patent or obvious.[230] In such a situation, a reasonable contractor standard applies, i.e., whether a reasonable contractor, under similar circumstances, would have been aware of the defect.[231]

E. Proportional Risk Allocation

Contract disputes resolution authorities such as the United States Court of Federal Claims and Boards of Contract Appeals may impose proportional risk allocation when the traditional risk allocation practice of placing

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[228] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 363 (3rd ed. 1995).
[229] Id.; see e.g., Blake Constr. Co., ASBCA No. 36303, 90-3 BCA ¶ 23,076 (determining that the duty of coordination does not apply in the case of a design defect); Hoffman Constr. Co., DOTBCA No. 2150, 93-2 BCA ¶ 25,803 (denying Government's reliance upon contractor's duty to coordinate where plans and specifications contained unsuitable dimensions and tolerances); Century Constr. Co., ASBCA No. 31702, 89-1 BCA ¶ 21,333 (determining that the duty of coordination does not apply in the case of a design defect, since no amount of coordination could have cured the defect).
[230] JOHN CIBINIC, JR. & RALPH C. NASH, JR., ADMINISTRATION OF GOVERNMENT CONTRACTS 365 (3rd ed. 1995).
[231] Id.

the entire risk on one party does not lead to a fair result.[232] A contractor may recover a percentage of increased costs resulting from unanticipated events or difficulties, based upon the determination that the Government and the contractor should share responsibility for the difficulties encountered.[233] This theory is grounded upon the principle of mutual mistake, and the contract is reformed as a matter of equity so that each side bears a share of the unexpected costs in proportion to the parties' responsibility.[234]

F. Variable Quantity Contracts

In variable quantity contracts, the Government must include realistic estimates in a solicitation.[235] Reliable estimates are necessary in order to provide equal information to all offerors as to the Government's expected requirements for supplies or services.[236] The estimate is

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[232] See id. at 373.
[233] Id.
[234] Id.; see e.g., ACS Constr. Co., ASBCA No. 28488, 84-1 BCA ¶ 17,179 (finding joint fault between contractor and Government and allocating costs equally); Environmental Growth Chambers, Inc., ASBCA No. 25845, 83-2 BCA ¶ 16,609 at 82,601 (finding joint negligence of the parties caused damage and therefore each was liable for increased costs).
[235] See FAR § 16.503(a)(1).
[236] See id.

not a representation to an offeror or contractor that the estimated quantity will be required or ordered.[237] Nor does an estimate guarantee that conditions affecting requirements will be stable or normal.[238] The contracting officer may obtain the estimate from records of previous requirements and consumption, or by other means, and should base the estimate on the most current information available.[239]

The Government is not required to order the estimated quantities set forth in the contract; however, the Government is obligated to use reasonable care in calculating the estimated quantities.[240] In calculating an estimate, the Government is not required to be clairvoyant but is obligated to base the estimate on all relevant information that is reasonably available.[241]

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[237] Id.
[238] Id.
[239] See FAR § 16.503(a).
[240] Womack v. U.S., 182 Ct. Cl. 399, 389 F.2d 793 (1968); DPS, Inc., ASBCA Nos. 32869, 34579, 92-1 BCA ¶ 24,664.
[241] Womack v. U.S., 182 Ct. Cl. 399, 389 F.2d 793 (1968); DPS, Inc., ASBCA Nos. 32869, 34579, 92-1 BCA ¶ 24,664.

G. Negligent Government Estimates

Negligent estimates occur most often when the Government fails to consider all relevant, available information.[242] A Contracting Officer should insure that the estimate is based upon the most accurate information available.[243] Examples of useful information are available workload figures, previous years orders, and information from end-users about their projected needs and budgets.[244] Application of statistical methods such as regression analysis, using more than one year's requirements history, or double-checking the effectiveness of an estimating procedure based on past performance may be useful in improving accuracy, but are not mandated.[245]

The Government is not required to search for or create additional information.[246] The Government is only required

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[242] Crown Laundry & Dry Cleaners, Inc., ASBCA No. 28889, 85-2 BCA ¶ 18,003; Apex International Management Services, Inc., ASBCA Nos. 37813, 38278, 38297, 38178, 38514, 38224, 38354, 94-1 BCA ¶ 26,299, *aff'd on recon.* 94-2 BCA ¶ 26,811; Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992).

[243] See Crown Laundry & Dry Cleaners, Inc., ASBCA No. 28889, 85-2 BCA ¶ 18,003; Apex International Management Services, Inc., ASBCA Nos. 37813, 38278, 38297, 38178, 38514, 38224, 38354, 94-1 BCA ¶ 26,299; Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992).

[244] Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992).

[245] Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992).

[246] Id.; see also American Marine Decking Services, Inc., ASBCA Nos. 44440, [], 97-1 BCA ¶ 28,821.

to use information that is reasonably available.[247] The mere existence of a variance between estimates and actual requirements does not necessarily give rise to liability by the Government.[248] However, the failure by Government personnel to verify the estimates provided by the user, after recognizing some potential inaccuracies, is negligence for which a contractor may recover.[249]

A Government official who prepares an Invitation For Bids but does not question the estimates or attempt to verify the estimates with reasonably available information is negligent, entitling the contractor to an adjustment.[250] Similarly, the failure of the Government to look at the prior year's actual usage, as compared to the prior year's estimates, was found to be a failure to observe the standard of reasonable care.[251]

The Government has been found negligent in the preparation of its estimate for not providing stocking data

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[247] Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992); see also American Marine Decking Services, Inc., ASBCA Nos. 44440, [], 97-1 BCA ¶ 28,821.
[248] Crown Laundry & Dry Cleaners, Inc. v. U.S., 29 Fed. Cl. 506, 520 (1993).
[249] Id.
[250] McCotter Motors, Inc., ASBCA Nos. 30498, 30997, 86-2 BCA ¶ 18,784; Chemical Technology, Inc. v. U.S., 645 F.2d 934, 945-56, 227 Ct. Cl. 120, 138-39 (1981).

readily available to it from the previous contract.[252] However, where there was no previous contract, the Government may base estimates on related information reasonably available from the period preceding the issuance of the solicitation.[253]

The Government is negligent when it unreasonably fails to update solicitation work estimates with the most current and reliable data.[254] For example, in Fairfax Opportunities Unlimited, Inc., the Department of Agriculture (USDA) issued a solicitation for a requirements contract for a variety of services, including the operation of a copy center and fifteen additional satellite centers.[255] During a scheduled pre-solicitation conference, the potential offerors questioned the estimated quantity.[256] Noting that the solicitation was issued on 13 April 1994, the offerors recognized that the estimated quantity did not take into

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[251] Pied Piper Ice Cream, Inc., ASBCA No. 20605, 76-2 BCA ¶ 12,148.
[252] Independent Manufacturing & Services Companies of America, Inc., ASBCA No. 47199, 95-1 BCA ¶ 27,561.
[253] See Ralph Construction, Inc. v. U.S., 4 Cl. Ct. 727, 727-28, 732 (1984)(finding Government exercised reasonable care in preparation of estimated quantities for housing maintenance services contract previously performed in-house, basing estimate on completed service orders and work orders performed by government personnel during the 12-month period preceding the issuance of the solicitation).
[254] Fairfax Opportunities Unlimited, Inc., AGBCA No.1 96-178-1, 98-1 BCA ¶ 29,556.
[255] Id. at 146,521.

account additional fiscal year (FY) 1994 data.[257] The offerors requested historical data on the acquisition.[258] In response, the USDA issued an amendment that provided the historical data for the month of December 1993, but no data from FY 1994.[259] Additionally, the historical data that was provided, labeled as "December 1993," actually contained the figures for November 1993.[260]

During contract performance Fairfax discovered that the estimated quantity of six million copies was twenty percent greater than the actual number ordered by the USDA.[261] Fairfax claimed the estimates were prepared negligently in that the Government failed to provide realistic or valid estimates of copy requirements.[262] The board concluded that the Government had a duty to provide

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[256] Id.
[257] Id.
[258] Id.
[259] Id.
[260] Id. The significant difference between the actual quantity usage for the two months boosted Fairfax's confidence in the Government's estimate. Id.
[261] Id. at 146,516.
[262] Id. Fairfax requested an equitable adjustment. Id. The Contracting Officer denied the request, and Fairfax appealed. Id. The appeal focused on the USDA's total estimated quantity of six million copies for the Fiscal Year 1995. Id. CLIN 1003 required offerors to submit a per cost price based on the Government's six million dollar estimate. Id.

offerors its most current and reliable data.[263] The board ruled that the Government acted negligently when it provided only one month of historical data when it had five months of data.[264]

Failure to include significant factors can lead to a negligent estimate. In Datalect Computer Services, Ltd. v. United States, the Army awarded a fixed-price requirements contract to Datalect for the maintenance and repair of computers in Germany and Italy.[265] The solicitation included an estimate of the government's requirements for the computer maintenance and repair services.[266] The Army based its estimate on historical workload information from FY 1991, which showed an average of sixty to sixty-five service calls per day.[267] Datalect's actual rate was forty-eight percent lower than the Government estimate.[268]

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[263] Id. The board ultimately determined that the USDA did not provide Fairfax with the most current and reliable data that was reasonably available. Id. at 146, 521.
[264] Id. at 146, 524.
[265] Datalect Computer Services, Ltd. V. U.S., 40 Fed. Cl. 28, 30-31 (1997).
[266] Id. at 30.
[267] Id.
[268] Id. The solicitation provided that the successful bidder would be the exclusive contractor for maintenance and repair requirements, and that the Government would purchase all its requirements from the contractor. Id. The solicitation stated that the estimates were not actual purchases, and the contractor was not entitled to a price

Datalect submitted a claim for an equitable adjustment, arguing that its bid price was unrealistically low because the Government failed to consider all relevant facts that could affect the Government's estimate.[269] The Army denied the claim, and on appeal, Datalect alleged that the Army breached its duty to consider relevant information when it compiled the workload estimates.[270]

The Government argued that the estimate was not prepared negligently, because it based the estimates on the most recent historical data that was reasonably available at the time it issued the solicitation.[271] The Government also asserted that the contract specified (and Datalect knew) that the estimate was not a guarantee that the Army would purchase the entire quantity stated in the estimate.[272] The court ruled for Datalect, concluding that

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adjustment if the Government failed to order the maximum estimated quantity. Id.

[269] Id. Specifically, Datalect claimed that the Army failed to consider troop drawdowns in Europe since 1991, the purchase of new computers with extended warranties, and the turn-in of outdated computer equipment. Id. In addition, Datalect identified in-house maintenance as a factor contributing to the reduction of service calls. Id. During oral arguments the Army acknowledged knowing of these factors that could impact the call rate. Id. at 36.

[270] Id.

[271] Id.

[272] Id. at 37.

the Army knew of the additional factors and that it did not consider them when determining the contract estimates.[273]

In indefinite quantities contracts, the Government agrees to purchase a guaranteed minimum quantity of an item and is only obligated to order that minimum quantity.[274] Whether estimates are negligently prepared or not is not material in this type of contract, in light of the Governments legal obligation to order only the guaranteed minimum.[275]

The risk associated with variances between actual purchases and estimated quantities is on the contractor.[276] Estimated quantities are not guarantees or warranties of quantity.[277] The contractor bears the burden of proof that the Government's estimate was inadequately or negligently prepared,[278] or that the estimate is unreasonable.[279]

The Government will not be liable for the differences between the actual and estimated quantities unless the

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[273] Id. at 36.
[274] FAR § 16.504.
[275] C.F.S. Air Cargo, Inc., ASBCA No. 40694, 91-2 BCA ¶ 23,985.
[276] Administration of Government Contracts, Nash & Cibinic, Third Edition (1995) at 239.
[277] Id.
[278] Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992).

contractor can show by a preponderance of the evidence that the estimates were inadequately or negligently prepared, not made in good faith, or grossly or unreasonably inadequate at the time they were made.[280] A large disparity between estimated and actual quantities does not shift the burden to the Government.[281]

The Contractor has the burden to prove that an increase in costs was the direct result of the difference in quantity.[282] An equitable adjustment is to be determined solely on the basis of differences in cost resulting from the larger or smaller quantity.[283] Even if a Government estimate is inaccurate due to math errors, the contractor will not recover if he fails to show that his bid would have been higher but for the Government's error.[284]

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[279] Apex International Management Services, Inc., ASBCA Nos. 37813, 38278, 38297, 38178, 38514, 38224, 38354, 94-1 BCA ¶ 26,299, *aff'd on recon.* 94-2 BCA ¶ 26,811.
[280] Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992).
[281] Id.
[282] Victory Construction Co. v. U.S., 206 Ct. Cl. 274, 510 F.2d 1379 (1975).
[283] Id.
[284] E&S Diversified Services, Inc. ASBCA No. 46898, 96-2 BCA ¶ 28,513.

In order to recover for an unreasonably inaccurate government estimate, a contractor must act reasonably and rely on that estimate.[285]

Variation in Estimated Quantities (VEQ) clauses provide for price changes when Government requirements vary from the estimate by more than the stated amount in the VEQ clause.[286] VEQ clauses do not protect the Government from liability for negligent estimates.[287]

The argument that Variation in Workload clauses entitle a contractor to recover only upon a showing of large differences between the estimated quantities and the actual quantities experienced has been rejected.[288] Contractors still must prove they relied on the estimates when bidding the contract.[289] In Lear Siegler, the contractor sought additional compensation in a motor pool maintenance contract for variation between the Government's

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[285] Emerald Maintenance, Inc., ASBCA No. 42,908, 94-2 BCA ¶ 26,904.
[286] FAR § 52.211-18. Variation in Estimated Quantities clauses ordinarily do not require reliance as a prerequisite to recovery under the clause.
[287] Integrity Management International, ASBCA No. 18289, 75-1 BCA ¶ 11,235, *modified* 75-2 BCA ¶ 11,602.
[288] Lear Siegler Inc./Management Services Division, ASBCA No. 30147, 88-2 BCA ¶ 20,642 at 104,339.
[289] Id.

estimated workload and actual workload.[290] The Armed Services Board of Contract Appeals determined that although the contractor's interpretation of workload estimates provided by the Government was reasonable, his claim for additional compensation was denied because he did not show that he had relied on that interpretation in preparing his bid.[291]

The contractor may find a remedy for variations between Government estimated workloads and actual workloads through constructive change clauses or a provision in the contract that addresses defective government estimates. Absent such a provision, the contractor's remedy is for breach of contract.[292]

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[290] Id. at 104,340.
[291] Id. at 104,350.

Chapter V. The Regions 3 & 4 Negligent Estimates Claim

A. Nature of the claim

The central issue in the case of Humana Military Healthcare Services, Inc. before the Armed Services Board of Contract Appeals is whether the Government acted in good faith and used reasonable care in developing its projections of the costs of providing mental health care services in connection with the solicitation for managed care support services within Regions 3 and 4 of the Military Health System.[293] The Request for Proposal (RFP) was issued on August 1, 1994. The Government projected costs for the one-year period prior to the start of health care delivery, called the Data Collection Period or DCP.[294] The contract was awarded and performance under the contract began on November 28, 1995. The DCP was established after

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[292] See Atlantic Garages, Inc., GSBCA No. 5891, 82-1 BCA ¶ 15,479.
[293] Appeal of Humana Military Healthcare Services, Inc., ASBCA No. 51988 (pending). HMHS brought the appeal on behalf of its subcontractor for mental health services under the managed care support contract, CHOICE Behavioral Health Services. On or about April 12, 2001, TMA and HMHS agreed to a global settlement of all outstanding modifications, claims, and requests for adjustments. Terms regarding the mental health services claim underlying the HMHS appeal were included in the global settlement. The settlement terms regarding the mental health services claim are currently pending review and approval by ASBCA.
[294] RFP, *supra* note 149, at § G-5a(3).

contract award as July 1, 1995 through June 30, 1996. Health care began following the end of the DCP.

The Government used civilian purchased health care (CHAMPUS) claims data and military provided health care (Military Treatment Facility or MTF) cost data in developing the DCP projections.[295] Because of time lags in receiving claims, TMA determined that CHAMPUS data was not sufficiently reliable until the February following the close of the fiscal year.[296] The Contracting Officer recognized the inherent difficulty in using incomplete claims data to project future health care costs.[297] The underlying cost data that was available to the Government during the solicitation, from fiscal years 1991 to 1994, was provided to the Offerors, so that the Offerors could perform their own analysis of the data.[298]

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[295] Contracting Officer Final Decision (hereinafter CO Decision), Contract No. MDA906-96-C-0002, HMHS 98-0511, dated November 18, 1998, at page 5.
[296] Id. at pages 5 and 9. CHAMPUS claims were accepted up to one year from the date of delivery of health care services.
[297] Id.
[298] RFP, *supra* note 149, Amendments 0004, 0010.

B. The Bid Price Adjustment

According to the TMA Contracting Officer, the Bid Price Adjustment (BPA) process was incorporated into the contract to mitigate the uncertainty in the underlying cost data used to develop the projections.[299] The Offerors were advised that the projections would be changed during the course of the procurement to reflect actual costs.[300]

Following the first BPA, there was a variance between the projections of costs and the actual costs (13percent overall and 42percent in mental health).[301] In the Final Decision, the Contracting Officer determined that there was no data available to the Government at the time of the solicitation that would have enabled it to more accurately predict the actual costs for the DCP.[302]

The Government provided the Offerors with DCP projections for all health care, including mental health services.[303] Offerors were also provided purchased care

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[299] CO Decision, *supra* note 295, at pages 3-4. For further discussion of the Bid Price Adjustment (BPA) process in the managed care support contracts, see *infra* notes 347-360 and accompanying text.
[300] Id.
[301] Id. at page 11.
[302] See generally id.
[303] RFP, *supra* note 149, Amendment 0004.

(CHAMPUS) and direct care (MTF) data for FYs 91-94.[304] In accordance with the RFP, an Offeror's trend factors and assumptions could be varied to account for the Offeror's beliefs as to the accuracy of the Government's projections and the Offeror's own analysis and interpretation of the data provided.[305] The Government's projections along with the Offeror's trend factors were required to be used when submitting the Offeror's proposal.[306]

In the pre-proposal conference, the Government told the Offerors to use the Government estimates, but the bidders were also advised that the Government estimates certainly would not be correct and that there would be adjustments made to it.[307] The Government did not disclose how the Solicitation's DCP projections were developed, and none of the offerors inquired how the projections were developed.[308]

The Contracting Officer's Final Decision indicates that the DCP projections were based upon FY93 data. The Final Decision further indicates that the Government

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[304] Id.
[305] Id.
[306] CO Decision, *supra* note 295, at page 6.

compared the FY93 data and FY94 data and determined that because the difference between the two sets of data was only 3.5 percent and there was inherent uncertainty in the data because of incompleteness, the significance of the 3.5 percent difference (incomplete data or true drop) could not reasonably be determined and therefore the DCP projections should not be updated.[309] The 7 percent difference between the two sets of data related only to mental health costs was also considered indistinguishable.

The Solicitation stated that the Government may revise the DCP projections prior to preliminary proposals or Best and Final Offers ("BAFO").[310] The Government judged in this case that the DCP projection should not be updated.[311]

The Government acknowledged that actual costs showed an overall decrease in health care costs of 13 percent ($676 projected costs and $591 million actual costs) compared with DCP projections, and a decrease in mental health care costs of 42 percent compared with DCP

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[307] Transcript of Pre-Proposal Conference, September 8, 1994, pages 37-41.
[308] CO Decision, *supra* note 295, at pages 7, 12-13.
[309] Id. at page 6.
[310] See id.
[311] Id.

projections.[312] According to the Government, the 42 percent drop was unprecedented, unexplainable, and could not have reasonably been predicted based on the data available to the Government at the time.[313]

The Government advised offerors that a downward price adjustment was a distinct possibility in this contract.[314] The downward price adjustment was the result of the application of the bid price adjustment model adjusting for the variance between the projections of cost and the actual costs.[315] This was the essence of the BPA process, ensuring that the prices were not determined based on projected DCP costs, but on a firm estimate of actual costs after the DCP is completed.[316] The bid price adjustment mechanism was developed to protect the Contractor and the Government from assuming more than a fair share of the risk associated with managed care support contracts.[317]

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[312] Id. at page 11.
[313] See id.
[314] See Transcript of Pre-Proposal Conference, September 8, 1994, pages 37-41.
[315] CO Decision, *supra* note 295, at page 12.
[316] Id.
[317] Id. at page 11.

C. Discussion of the claim

HMHS's central argument in this complaint is that the Government breached its obligation to provide accurate and reliable estimates related to the mental health services portion of the managed care support contract because those estimates varied from the actual costs for mental health services by over 40percent. HMHS disputes only that portion of the government's estimates that relates to mental health, which accounts for approximately 9percent of the total contract price. As determined through the first bid price adjustment under the contract, the overall variance between the Government's projections and actual costs was approximately 13percent.[318] HMHS sought entitlement based upon the degree of variance between the mental health services projected costs and the mental health services actual costs.[319]

HMHS's requested relief equals the amount of the first bid price adjustment which relates to the variance between the mental health services projected costs and the mental

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[318] Id.
[319] See id.

health services actual costs.[320] In Medart, Inc., v. Austin, the United States Court of Appeals for the Federal Circuit affirmed the decision of the General Services Administration Board of Contract Appeals, rejecting Appellant's demand for reimbursement of losses incurred in the performance of a requirements contract because of variance between actual orders and the government's estimated requirements. [321] The court determined that because actual purchases vary significantly from government estimates does not ordinarily give rise to liability on the part of the government.[322] The court stated that the government must act in good faith and use reasonable care in computing its estimated needs.[323] The court concluded that the government used information that was reasonably available, and noted that the government need not search for or create additional information.[324]

The plaintiffs in Womack v. United States sought relief for, among other claims, a variance in the

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[320] See id.
[321] Medart, Inc. v. Austin, 967 F.2d 579, 580 (Fed. Cir. 1992).
[322] Id. at 581.
[323] Id.
[324] Id. at 582, *citing* Womack v. United States, 389 F.2d 793, 801 (Ct.Cl. 1968); *accord* Chemical Technology, Inc., v. United States, 645 F.2d 934, 946, (Ct.Cl. 1981).

government's estimates regarding the percentage of townships in Utah that could be platted on a standard diagram.[325] A respected and experienced engineer made the estimate after reviewing plats from locations throughout the State of Utah.[326] The United States Court of Claims rejected Appellant's argument that the Government's estimate should be deemed a misrepresentation because it ultimately proved to be so wide of the mark (85 percent estimated v. 55 percent actual = 30 percent variance).[327] The court concluded that the contention was without merit because error per se is not misrepresentation.[328] The court determined that both parties exercised reasonable care and diligence in arriving at and testing the accuracy of the 85percent estimate.[329] It was only the actual experience of performing the contract that demonstrated that they were both badly mistaken in their forecasts.[330] When they entered into their contract, both parties knew that the actual total number of regular townships could not feasibly

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[325] Womack v. United States, 389 F.2d 793, 801 (Ct.Cl. 1968).
[326] Id.
[327] Id.
[328] Id.
[329] Id. at 802.
[330] Id.

be determined in advance of performance.[331] The Government had informed plaintiffs as best it reasonably could for bidding purposes, and they had confirmed its estimation by their own investigation.[332] The court concluded that, though both parties were substantially mistaken as a matter of fact, the plaintiffs were not entitled to equitable relief because their contract cast on them the risk of just such a contingency.[333]

In Emerald Maintenance, Inc., the Armed Services Board of Contract Appeals determined that the fact that actual experience varies significantly from data furnished in a government solicitation and does not, standing alone, create liability nor shift to the government the burden of proving the reasonableness of its data.[334] The contractor still bears the burden of showing by a preponderance of the evidence that the Government's data was inadequately or negligently prepared.[335]

Court decisions caution against the temptation to depart from the reasonable standard set forth in case

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[331] Id.
[332] Id.
[333] Id. *citing* 3 Corbin, Contracts § 598, at 585-586 (1960).

decisions, and to unreasonably view deviations from the vantage point of hindsight. It is the standard of care employed by the government viewed with foresight and not with hindsight that must be examined in these cases.[336] In promulgating an estimate for bidding-invitation purposes, the government is not required to be clairvoyant but it is obliged to base that estimate on all relevant information that is reasonably available to it.[337] In Womack, the United States Court of Claims concluded that the government's total failure to consult records or inquire of information that was there for the asking but not sought, constituted a material misrepresentation of estimates of card quantity.[338] The court determined that the estimate that is made must be the product of such relevant underlying information as is available to the author of the invitation.[339] Assuming that the bidder acts reasonably, he

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[334] Emerald Maintenance, Inc., ASBCA No. 42908, 94-2 BCA ¶ 26,904, at 133,970.
[335] Id.
[336] American Mainenance and Management Service, Inc., ASBCA No. 18756, 65-2 BCA ¶ 11,406 (1975).
[337] Womack v. United States, 389 F.2d 793, 801 (Ct.Cl. 1968); see Arkie Lures, Inc. v. Gene Larew Tackle, Inc., 199 F.3d 953, 955 (Fed. Cir. 1997), quoting from Loctite Corp. v. Ultraseal Ltd., 781 F.2d 861, 872 (Fed. Cir. 1985), *overruled on other grounds*, Nobelpharma AB v. Implant Innovations, Inc., 141 F.3d 1059 (Fed. Cir. 1998).
[338] Womack v. United States, 389 F.2d 793, 800 (Ct.Cl. 1968)
[339] Id. at 801.

is entitled to rely on government estimates as representing honest and informed conclusions.[340] This standard thus places a burden on the bidder to also act reasonably. Similarly, in Crown Laundry & Dry Cleaners, Inc., the Armed Services Board of Contract Appeals determined that in a requirements contract providing estimates of future quantities, the Government has a duty to consider all relevant information in preparing estimates included in a solicitation.[341] The government fails to use due care when it ignores all relevant information.[342] The Board in Crown Laundry determined that more current and clearly reliable laundry workload figures were available to the Government.[343] The Government did not consider the new information and did not release the new information simply because of regulations prohibiting release of the data before it had been audited.[344] There was no determination by the Government as to the quality and reliability of the

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[340] Id. *citing* Snyder-Lynch motors, Inc. v. United States, 292 F.2d 907, 909-10 (Ct.Cl. 1961).
[341] Crown Laundry & Dry Cleaners, Inc., ASBCA No. 28,889, 85-2 BCA ¶ 18,003 (1985).
[342] Id.
[343] Id.
[344] See id.

data.[345] The Board determined that the Government failed to use due care in not considering the data in preparing the estimates.[346] In the HMHS case, the Government asserts that it's rationale for not using the partial FY 95 health care purchased care claims data is directly related to the quality and reliability of the data, not to a regulation.

In the managed care support contracts, the RFP provides guidance on the mechanics of the contract. The Government's position in the appeal is that the operation of the bid price adjustment merely made the adjustments to the contract price that were outlined in the Request for Proposal.[347] The Government cites a pre-proposal conference, during which the offerors were informed that there would be adjustments to the Government estimates.[348] The Government outlined five major adjustments that would occur to the winning offeror's price:

> Okay, so if once you've built up your bid price and you've submitted it, and win the contract, there are a number of things that happen to your bid price. There are a number of adjustments

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[345] See id.
[346] Id.
[347] CO Decision, *supra* note 295, at page 12.
[348] Transcript of Pre-proposal Conference (Sept. 8, 1994) pages 37-41 and Slides pages 7-8.

that occur to it that are important to understand in terms of your pricing strategy.

First I mentioned at the outset that you had to use the actual data-the actual DCP data that are provided by the government. However, this is an estimate made by the government and **certainly the government estimate will not be correct. There will be adjustments made to it.**

So during the first and second option periods of the contract the government's estimates of health care in the data collection period as well as estimates of MTF activity and eligibles will be replaced with the actual values that have occurred for those periods. So that whatever happens, **your price will be adjusted.**

So for example if an in-patient med/surg care in Region 3 for active duty dependents, we estimate the data collection period those costs are 100 million and the costs actually turn out to be 110 million, what'll happen is your prices in that - in that category will be adjusted upwards by 10 percent. So your prices will be adjusted based on actual data and once we replace it-once we replace the estimated values.

In a similar fashion we also will replace the government's estimate of CHAMPUS eligibles. This occurs throughout the contract, so even though the government's made an estimate of how many beneficiaries there'll be over time, if it turns out there-they're going to be five percent more, your price'll get **adjusted upward by five percent. If they're five percent fewer, your price'll get adjusted downward.**

A third adjustment is for actual MTF utilization. I talked before about the O factor. If the number of NASs goes up, your price'll be adjusted upward. If the number of NASs goes down **your price gets adjusted downward.** Similarly of

out-patient visits. In addition there is an adjustment that'll be made in the contract if the case mix in the MTF and in CHAMPUS move in opposite directions. So that if the inpatient case mix and the MTF goes down and the CHAMPUS in-patient case mix goes up, your prices for in-patient care will be adjusted. So that's another item that there's some adjustment over time if there are shifts in that.

The fourth adjustment has to do with actual price inflation and changes in CHAMPUS reimbursement. When you read the RFP you'll discover that you must use the government's estimate of inflation in preparing your bid.

However, the government allows you-if you don't like that estimate you're allowed to add in this other category your own adjustment to that.

But if the government estimate of CHAMPUS reimbursement changes turns out not to be correct, **your price will also be adjusted over time.** So we've-we've estimated that in the year 2000 there'll be certain levels of reimbursement for certain types of care. If it turns out that that's incorrect, **your price'll be adjusted either upward or downward for the actual values.**

The fifth change-the fifth adjustment that occurs, I mentioned previously, is risk sharing. At the end of each of the option periods we will do a comparison of this adjusted bid price which, remember is the bid price in your proposal adjusted for changes in eligibles, MTF activity, et cetera-the four things I showed in the previous page.

We will compare that value with your actual health care costs and the government and the contractor will then share in any overruns or underruns. This is described as well in-in your RFP

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> Okay. Finally, as I mentioned at the outset, even though it is a fixed price contract, there are all these adjustments and particular risk sharing, which means that **the government may end up paying a higher or lower price than the winning Offeror's bid.**[349]

The negligent estimates cases discussed above involve government contracts requiring estimates of metal storage cabinets, index cards, road construction and diesel engine repair. The contract requirements and the historical information available in these cases were much more complete and accessible than the healthcare services sought under the Managed Care Support Contracts. The Government advised all the offerors at the Pre-Proposal Conference that the Government estimate would not be correct and that there would be adjustments made to it.[350] The offerors were advised to develop their own estimates or trend assumptions penetration rates and volume tradeoff factors.[351] The bidders were also provided the underlying data that was

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[349] Id. (Emphasis added).
[350] See id.
[351] RFP, *supra* note 149, § G-5a; see CO Decision, *supra* note 295, at page 10.

used to develop the DCP projections, so they could perform their own analysis of the data.[352]

The Government instructed the offerors that the bid price adjustment ("BPA") would substitute the government projections of the health care services for the actual data on the health care services delivered.[353]

In Caffall Bros. Forest Products, Inc. v, United States, the plaintiff sought to recover for alleged breach of contract for the sale of timber.[354] The Court of Claims, in upholding the denial of plaintiff's claim, determined that the Government did not warrant the estimated quantities of timber.[355] The court noted:

> Careful consideration of the relevant facts of this case leads to the conclusion that Defendant did not warrant that Plaintiff would be able to purchase, cut and remove 13,300 MBF of merchantable timber from the Skogi sale, that Plaintiff was told to rely upon and in fact did rely upon its own investigation of the proposed Skogi sale, and that in all circumstances the estimated quantity of timber stated in the Skogi contract was not "the basis of the agreement between Plaintiff and Defendant." Everett Plywood

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[352] RFP, *supra* note 149, Amendments 4, 10 ; see CO Decision, *supra* note 295, at page 10.
[353] CO Decision, *supra* note 295, at page 6.
[354] Caffall Bros. Forest Products, Inc. v. U.S, 678 F.2d 1071, 1072 (Ct. Cl. 1981).
[355] Id. at 1076.

and Door Corp. v. United States 190 Ct. Cl. at 94, 419 F.2d at 433.[356]

The court in Caffall held that, even in the absence of a strong disclaimer, there would be no warranty of reasonable accuracy of an estimate if the purchaser is instructed to rely upon its own estimate and does in fact substantially rely upon it.[357] An issue in the HMHS appeal is whether HMHS relied primarily on its own knowledge and experience in developing its price estimates.

In the evaluation of the bid offers, the Government's projections were used in conjunction with the offeror's trend factors to formulate a bid price.[358] The trend factors represented the amount of cost savings each bidder believed it could achieve.[359] The offerors understood that the projections/estimates would change based upon the actual amount of health care delivered and that the compensation they received under the contract would not necessarily be the bid price.[360]

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[356] Id.
[357] Id. at 1077.
[358] See CO Decision, *supra* note 295, at pages 6-7.
[359] See id.
[360] See id.

The basis for the appeal by Humana Military Healthcare Services, Inc. is that the government failed to use all the information available in its projections.[361] The difficulty HMHS faces is in attempting to compare data of paid health care claims with data on meals served in a military dining facility where the only variable would be the number of reservists that would be dining at the facility over the year. This comparison is perhaps inequitable, because the number of meals served from one location in the previous year can be readily determined, but projecting health care costs based upon claims data flowing from civilian health care providers throughout the nation, as well as health care service records (HCSRs) from military treatment facilities from three separate military branches for which at the time there was no central repository, is more uncertain because of the incompleteness of the data.

Health care claims data typically flows at a sporadic rate. Claims processing issues can cause data to be inaccurate at any given time. In attempting to project future costs from the claims data available at the time the DCP projections were made, the Government operated under

[361] See id. at pages 1-3.

the assumption that data on paid health care claims for a fiscal year is not accurate and reliable for approximately 15 months after the beginning of the fiscal year.[362] For example, FY 93 (October 1992-September 1993) was not considered accurate and reliable for Government estimating purposes until January 1994.[363]

The TMA Contracting Officer's Final Decision states that that FY 91-92 data were considered when completing the DCP projections, but the FY 93 data was used as the basis for the DCP projections.[364] The FY 94 data were 15 months complete in early January 1995, and the Government determined that the FY 94 data were indistinguishable from the FY 93 data.[365] Therefore, the Government decided not to update the DCP projections.[366] The Government's decision must be properly scrutinized, recognizing however that it is the standard of care employed by the Government viewed with foresight and not with hindsight that must be examined.[367]

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[362] See id. at page 5.
[363] See id.
[364] Id. at pages 8-9.
[365] Id.
[366] Id.
[367] American Maintenance and Management Service, Inc., ASBCA No. 18756, 75-2 BCA ¶ 11,406 (1975).

The case of Medart, Inc. v. Austin and FAR § 16.503 provide that the Government *should* base the estimate on the most current information available.[368] When dealing with health care claims data with inherent uncertainty, the most current data may not be the most accurate and reliable. The Government suggests that it complied with the above requirements in that it carefully considered the most current information available (FY 94 data), and then made a careful determination not to update the projections.[369] The Government determined that the historical downward trend in health care costs was decelerating towards an end in the downward trend, and the initial evaluation of the FY 94 data supported this interpretation.[370] Due to the incompleteness of the data, the 3.5percent overall difference and the 7percent difference in mental health between the FY 93 and the FY 94 data rendered the data indistinguishable.[371] The Government asserts that because the Government reasonably considered the FY 94 data, the Government did base the DCP projections on the most current

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[368] See Medart, Inc. v. Austin, 967 F.2d 579 (Fed. Cir. 1992); see also FAR § 16.503.
[369] CO Decision, *supra* note 295, at pages 6-9.
[370] Id.

information available.[372] In addition, the offerors were provided the FY 94 data so that they could make their own interpretations of the data.[373] Appellant had already been provided FY 91- FY 93 data.[374] Because the Government provided FY 94 data to Appellant, the Government did not have superior knowledge over and did not mislead Appellant.[375]

In the Military Health System, there is interaction between the purchased care system and the direct care system, creating problems when attempting to analyze only one set of system data.[376] Purchased care is meant to supplement direct care, and this creates a dynamic environment where changes in one system (e.g., increased utilization) can have a direct impact on the other.[377] According to the TMA Contracting Officer, the balance

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[371] Id.
[372] Id.
[373] Id. at page 6.
[374] See id. at pages 6-9.
[375] See Odgen-HCI Services, ASBCA No. 32,169, 93-3 BCA ¶ 26,141 (1993), *adhered to on recons.*, 94-1 BCA ¶ 26,489 (1993)(Government had superior knowledge which it failed to share with bidders.)
[376] CO Decision, *supra* note 295, at page 5.
[377] See id.

between these two means of delivery is difficult to analyze in historical data.[378]

The Government's obligation to ensure that estimates are based upon all information reasonably available does not equate with the proposition that the Government would be absolutely required to update estimates upon receiving new information, regardless of the quality, reliability or accuracy of the new information. This interpretation would destroy the reasonableness standard that presently exists.

The Government asserts that the FY 94 data were reasonably considered, but because there were significant concerns about the reliability of that data when compared to the FY 93 data, the Government determined that updating the DCP projections was not appropriate.[379] The Contracting Officer who issued the Final Decision, determined:

> The BPA was developed to address the contract price over the aggregate of the categories of care. The Government did not intend to address each category separately. The Government has acted consistent with this intent both prior to the contract's award and since the contract's award. The Government viewed the aggregate change of 3.5percent from FY 93 to FY 94 was not significant enough to warrant a formal

[378] See id.
[379] Id. at pages 6, 14.

change to the projections. Similarly, when the initial and second BPAs were applied to the contract price, the aggregate contract price was altered, based on actual DCP data. No subordinate pricing structure exists that would allow the Government to control the price that HMHS pays to its subcontractors.[380]

[380] Id. at page 14.

Chapter VI. Conclusion

In the author's opinion, the path chosen by the Government in choosing and engaging in a methodology for projecting/estimating health care costs, including mental health costs, was reasonable and correct under the circumstances and limitations presented at the time of the solicitation of the Regions 3 and 4 managed care support contract. The BPA formula is designed to reduce the risk involved in projecting prices for a multi-year contract.[381] The BPA mechanism was developed as a health care price adjustment to protect both the contractor and the Government from unforeseen and uncontrollable influences in the health care industry over a five-year period.[382] The concern lies in the fact that with health care data, there is a time lag between the delivery of care and the time that the cost of that care is recorded in the data system.[383] Therefore, it takes an amount of time before the data is complete.[384] However, as the data becomes more complete and more accurate over time, the data becomes less

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[381] RFP § G-5a(1). For a discussion of the Bid Price Adjustment (BPA) process in the managed care support contracts, see *supra* notes 146-47, 299-317 and accompanying text.
[382] RFP § G-5a(2).

current. The Government must attempt to choose that point in time when there is a relatively high degree of confidence that the estimates or projections are based on data that are complete and accurate, but also reasonably timely.[385]

In the Regions 3 and 4 solicitation, the RFP was issued on August 1, 1994, and in the author's opinion the projections were reasonably based upon the most current, accurate and reliable data available at that time, i.e., the Fiscal Year 1993 data, in spite of the fact that the contract was not awarded until November 28, 1995. Fiscal Year 1994 data, although reasonably available, was substantially similar to the Fiscal Year 1993 data, and because of data uncertainty could not reasonably be distinguished from the Fiscal Year 1993 data, drawing caution against performing the time-consuming process of updating the projections and modifying the RFP.[386] The

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[383] CO Decision, *supra* note 295, at page 5.
[384] Id.
[385] Id. For a discussion of the Data Collection Period (DCP) process, see *supra* notes 295-298 and accompanying text.
[386] For a discussion of the Government's position that the Fiscal Year 1993 and Fiscal Year 1994 data were indistinguishable, see *supra* notes 364-80 and accompanying text. For a discussion of the variance between the Government's projected costs and the actual costs of the DCP, see *supra* notes 301-13, 318-60 and accompanying text.

Fiscal Year 1995 data was not sufficiently reliable or certain, even at the time of contract award. [387] The decision not to rely on the data for the purposes of projecting future costs was appropriate.

Updating the projections meant gathering new purchased care and MTF data, a time consuming and difficult process.[388] Because the data had not before been collected in the manner and for the purpose used in the MCSC solicitations, the process simply was not very fluid. The regional structure of the managed care support contract concept was new, and data that had been collected in different manners by each military treatment facility in each of the three military services had to be integrated, and that data had to be further integrated with civilian purchased care data in a way that had never before been attempted. The lack of standardization in data collection compounded the difficulty in projected future costs on a regional basis.

Decisions to update the projections meant that the projections would be presented, along with the underlying

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[387] For a discussion of the reliability of health care claims data, see *supra* notes 296-98 and accompanying text.

data, to the offerors through a modification to the solicitation. The offerors would then require a length of time to adjust their proposed trend factors and prices before submission of BAFOs. This lengthy process naturally affects the timeliness of the data used in the projections.

The initial development of the DCP projections is a very complex process, and there must be sufficient time to collect, verify and validate the underlying data used to develop the projections.[389] The subsequent lengthy process of modifying an RFP with updated data and additional BAFO preparation is equally complex and cumbersome. In view of the total circumstances surrounding the Regions 3 and 4 solicitation, the decision not to update the DCP projections was a reasonable and correct path to take.

TRICARE was established during a period of military downsizing and budget concerns to contain costs and maintain the quality of and access to health care for DoD's 8.2 million beneficiaries. DoD awarded seven competitive 5-year contracts totaling about $15 billion. The difficulty in estimating costs under the contracts did not

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[388] See CO Decision, *supra* note 295, at page 14.
[389] See id.

end with contract award. Since these contracts were awarded, DoD made numerous and continuous changes to them through contract change orders. [390] DoD has not been able to develop a reliable estimate of the total federal liability for the contract changes and neither systematically reviewed the need for each order nor considered its likely costs and other effects.[391] As of July 2000, over 500 change orders to the TRICARE contracts had not been settled and may represent a significant future liability to the Defense Health Program.[392] To address this growing backlog, DoD initiated a plan called Mobilization to settle all of its open change orders by December 2000.[393] Furthermore, in an effort to better control costs and improve health care contracting, DoD initiated a broad review of TRICARE's

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[390] Performance and Accountability Series, *Major Management Challenges and Program Risks: Department of Defense*, Government Accounting Office (GAO), GAO-01-244, January 2001, at 55-56.

[391] Id.

[392] Id.

[393] Id. GAO is monitoring and evaluating DOD's progress in settling change orders and identifying improvements to the process. Id. As discussed *supra* in footnote 293, on or about April 12, 2001, TMA and HMHS agreed to a global settlement of all outstanding change orders and claims. Terms regarding the mental health services claim underlying the HMHS appeal were included in the global settlement. The settlement terms regarding the mental health services claim are currently pending review and approval by ASBCA.

operational structure.[394] For the study, DOD will examine TRICARE's organization and business plans and will develop a revised procurement strategy.[395] Whether the current road taken by DoD to develop and launch the new procurement strategy and whether this new strategy will reduce the current volume of contract changes or control health care costs can only be answered at the end of that path.

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[394] Performance and Accountability Series, *Major Management Challenges and Program Risks: Department of Defense*, Government Accounting Office (GAO), GAO-01-244, January 2001, at 55-56.
[395] Id.